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London Borough of Wandsworth

Inspection of services for children in need of help and protection, children looked after and care leavers

and

Review of the effectiveness of the Local Safeguarding Children Board[1]

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

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

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Executive summary

The standard of social work practice for children and young people and the quality of leadership, management and governance have declined since children's services in Wandsworth were last inspected in June 2012. Services for children who need help and protection and for care leavers are inadequate. Leadership, management and governance in the borough have failed to prevent this serious decline.

Lack of effective scrutiny by senior leaders, elected members and managers means that they were not aware of the serious deficits concerning unsafe practice for too many vulnerable children until this inspection. Managers at all levels of the organisation do not have sufficient oversight of front-line practice. For children in need of help and protection, this has resulted in the inappropriate application of thresholds for intervention and service provision, delays in children and young people being seen by social workers and inadequate recognition and management of risk. This left some children at risk of harm. Strategy discussions take place solely with the police, which is not in line with statutory guidance and results in information not being shared appropriately. A number (10) of care leavers with high needs have spent unacceptably long periods in unsuitable accommodation without the necessary support being in place. This makes them more vulnerable.

The quality and regularity of social work supervision is improving but it does not yet assure good and safe enough practice. The implementation of the signs of safety and well-being framework is giving social workers a consistent model on which to base their practice, but this is not yet embedded well enough across all parts of children's services. There is good organisational support in place for social workers, who have low caseloads. However, there is a lack of management oversight and a failure to sufficiently challenge poor practice. This has left some children at risk of harm or experiencing drift and delay.

The local authority has a suite of widely distributed performance information, including data, that is used effectively in a variety of areas to improve practice. Nevertheless, inspectors found significant and fundamental gaps in the information reports. If available, this missing information would have alerted senior leaders and elected members to the fact that there were serious failings in the protection and support of children. Although the local authority has made extensive use of externally commissioned and internal audits, these audits either failed to identify the deficits found by inspectors or, where they did identify them, this did not lead managers to develop and implement robust action plans to improve services.

Where inspectors identified children at risk of significant harm, the local authority took decisive action to intervene and protect them. During the inspection, management oversight was strengthened in the referral and assessment service, including the multi-agency safeguarding hub (MASH). An audit was undertaken of recently closed cases. This led the local authority to review the closure decision in

15% of the cases audited and take further action to assess risk and need.

The quality of assessment and planning across all service areas is variable, ranging from inadequate to good. Poor-quality assessments are characterised by delays, insufficient account being taken of the child's history, failure to identify and accurately assess risk factors in the child's situation and insufficient engagement with the child and their family. Some children have been left for too long in situations where they are neglected. Plans are too vague, with a lack of specific and measurable outcomes by which to measure progress. Assessments and plans, including pathway plans, are not routinely updated to reflect changing needs or circumstances. Some children looked after are returned home from local authority care without a sufficient assessment or support plan in place.

Partnership arrangements to protect children at risk of child sexual exploitation are well established strategically and operationally via the sexually exploited multi-agency panels (SEMAP). These are not consistently underpinned by robust practice and more work is required to ensure that all sexually exploited children are effectively identified and protected. The number of return interviews completed after a missing young person is found is increasing. However, the risks of young people going missing are not managed consistently, nor are outcomes aggregated to inform wider intelligence about children and young people at risk of CSE or involved in risky behaviours such as substance misuse.

Although the local authority has various strategic strengths, for example user participation and workforce planning, and has clear accountability structures in place, it has not yet set up a corporate parenting board dedicated to and accountable for improving outcomes for children looked after and care leavers. This has left the inconsistency in the quality of service delivery unchallenged. Care leavers have insufficient accommodation and training and employment opportunities, and weak permanence planning has resulted in some children waiting too long for a permanent home.

Senior managers do not track permanence plans involving long-term fostering or adoption to ensure progress in achieving timely placements. Family-finding starts too late. The local authority's work to ensure sufficient good placements for looked after children and to commission these placements efficiently is underdeveloped. The local authority's sufficiency strategy recognises that there are insufficient fostering placements for children needing emergency placements, for adolescents and for brothers and sisters who need placements together. However, it does not address the need for suitable accommodation for care leavers with high support needs or the fact that none of the adopters currently approved are suitable matches for the children waiting. This results in insufficient placement choice, care leavers placed in unsuitable accommodation and in delays for children in need of adoptive homes.

Good support is provided to children in need of a placement by the access to resources team. The placement support team offers a variety of interventions to help maximise the success of placements. The virtual school monitors the education of

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children looked after and has been effective in improving educational attainment and outcomes for children and young people with complex needs. The quality of post-permanence support is good.

Social workers know their children well and some evidence of purposeful direct work was seen. Advocacy is provided through commissioned services. This is supporting young people to engage with the multi-agency meetings that concern them and helping to constructively resolve any complaints they may have.

An early help hub and a family information service help practitioners and families to access information on the range of services that make up the local authority's early help offer. This offer is benefiting an increasing number of children and families. The quality of early help assessments varies. The impact of the services provided is difficult to measure through the team around the child meetings. Nevertheless, parents spoken to said they had benefited from a wide range of support and advice, programmes and group activities, which are enabling them to develop their parenting skills. The Family Recovery project is improving outcomes for the children who it supports.

Participation is a strength in the local authority, and young people play a positive role in developing and improving services. Members of CLICK (the children in care council) and care leavers all spoke positively about their engagement with the local authority and the range of activities they are involved in that help to develop and improve services.

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The local authority

Information about this local authority area[2]

Previous Ofsted inspections

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

Local leadership

- The Director of Children's Services has been in post since April 2014.
- The chair of the Local Safeguarding Children Board has been in post since July 2011.
- The local authority bases its early help and social work practice on the Signs of Safety model.

Children living in this area

- Approximately 60,000 children and young people under the age of 18 years live in Wandsworth. This is 19% of the total population in the area.
- Approximately 22% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 20.3% (the national average is 15.6%)
  - in secondary schools is 19.3% (the national average is 13.9%).
- Children and young people from minority ethnic groups account for 43% of all children living in the area, compared with 22% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Mixed, Asian/Asian British and Black/Black British.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 46.1% (the national average is 19.4%)
  - in secondary schools is 44.7% (the national average is 15.0%).

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

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Child protection in this area

- At 31 October 2015, 1,731 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 1,826 at 31 March 2015.
- At 31 October 2015, 201 children and young people were the subject of a child protection plan. This is an increase from 193 at 31 March 2015.
- At 31 October 2015, seven children lived in a privately arranged fostering placement. This is no change from seven at 31 March 2015.
- Since the last inspection, five serious incident notifications have been submitted to Ofsted and one serious case review completed.

Children looked after in this area

- At 31 October 2015, 220 children are being looked after by the local authority (a rate of 37 per 10,000 children). This is the same as 220 (37 per 10,000 children) at 31 March 2015. Of this number:
  - 172 (or 78%) live outside the local authority area
  - 27 live in residential children's homes, of whom 92.6% live out of the local authority area
  - 145 live with foster families. Of these 145, 73.1% live out of the local authority area
  - two live with parents. Of these two, 0% live out of the local authority area
  - 15 are unaccompanied asylum-seeking children.
- In the last 12 months:
  - eight children have been adopted
  - 19 children became subject of special guardianship orders
  - 154 children ceased to be looked after. Of these 154, 18 subsequently returned to be looked after
  - 44 children and young people ceased to be looked after and moved on to independent living
  - 40 children and young people ceased to be looked after and are now living in houses of multiple occupation.

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Recommendations

1. Strengthen management oversight so that thresholds and child protection procedures are applied appropriately and robustly, ensuring that all children in need of help and protection are seen promptly and given the right service at the right time.

2. Ensure that robust performance information is available to support effective management scrutiny and challenge to poor practice at all levels of the organisation.

3. Improve the quality of audit activity so that managers and elected members have accurate information about the quality of practice across all teams and can use the findings to strengthen organisational and individual performance.

4. Ensure that all staff receive regular supervision, in line with the local authority's supervision policy, that provides direction and challenge to poor practice.

5. Ensure that strategy discussions comply with statutory guidance and that the skills and resources available in the MASH service are used more effectively to involve relevant partner agencies in information sharing, planning and decision making.

6. Ensure that care leavers currently placed in bed and breakfast accommodation receive comprehensive support based on a robust assessment of risk and that plans are in place to swiftly remove these young people from such unsuitable accommodation.

7. Establish a corporate parenting board dedicated to and accountable for improving outcomes for children in care and care leavers.

8. Ensure that the quality of social work, early help assessments and direct work with children is consistent. Also ensure that all plans detail specific actions, timescales and responsible individuals and are subject to regular review.

9. Ensure that children at risk of child sexual exploitation are consistently identified and protected.

10. Ensure that all children missing from home and care are routinely offered return home interviews so that risk can be managed effectively and outcomes analysed to inform intelligence.

11. Where cases are being considered for closure or step down to early help or targeted services, ensure that decisions are based on a thorough assessment of need and risk.

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12. Ensure that the local authority's sufficiency strategy is effective, so that it delivers placement choice, appropriate permanent homes for children who can no longer live with their birth parents and safe and suitable accommodation for care leavers.

13. Ensure that permanence decisions are implemented in a timely manner with regular scrutiny, challenge and oversight from managers and independent reviewing officers (IROs).

14. Review family-finding processes to ensure that these are timely and make best use of internal and external resources to secure permanent homes for children.

15. Where there is a plan for a child to return home, ensure that assessments evaluate the impact of the work completed with parents and children and evidence how improvements are to be sustained.

16. Ensure that the care leaving service provides a high-quality support for care leavers, in particular with regard to pathway planning and provision of a range of suitable accommodation and employment and training opportunities.

17. Ensure that the electronic social care recording system promotes good social work practice, supports effective managerial oversight and provides accurate performance information.

Summary for children and young people

- Services for children and young people are not good enough and need to get much better.
- Those children who need help and protection do not get the right services as quickly as they should.
- Although managers were not able to spot problems in services themselves, when inspectors pointed them out they were keen to sort them out as soon as possible.
- Parents who have difficulties managing at home say that support services in children's centres are a great help to them. Wandsworth has families from many ethnic backgrounds and those spoken to during the inspection feel that services welcome them.
- The best social workers are reliable, friendly and keep children and families up to date with what is happening. Inspectors found that some social workers need to improve what they do.
- When the council decides it needs to look after a child it is for a good reason. Sorting out a permanent home for a child does not happen quickly enough and the council needs to get children into a stable home sooner.
- Young people are positive about their foster carers and feel part of the family. However, the council finds it hard to attract enough foster carers.
- Almost all looked after children attend good or outstanding schools and their attendance is good. Those of primary age do well at school but those of secondary age do not do so well. More need to get good GCSEs.
- Not all young people who leave care move into suitable accommodation. This makes it difficult for them to get on with their lives. It is pleasing that some go on to study at university but worrying that too many others do not settle into education, work or employment.
- The children in care council, known as CLICK, is outstanding. It gives young people, council leaders and managers a place to share views and improve services. CLICK members enjoy holidays together and have been involved in revising the council's pledge to children looked after and care leavers and developing a welcome pack for children newly looked after.

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

Summary

The experiences and progress of children who need help and protection are inadequate. Serious concerns across the service leave children at risk of harm. Management oversight, the application of thresholds for intervention and the recognition of risk are weak in too many cases seen by inspectors. Case supervision is variable in both frequency and quality and in too many cases it is ineffective in protecting children and proactively driving plans forward.

In all cases seen, strategy meetings do not comply with statutory guidance, which means that information is not appropriately shared. The resources and the skill mix of other professionals based within the MASH service are not being used effectively either to share information or make effective decisions.

Managers and social workers have failed to recognise the need for a section 47 child protection investigation on far too many occasions. When concerns have been identified, the response to assess risk and provide appropriate protection has not been swift or robust enough. Unacceptable delays in visiting children have occurred too frequently, leaving these children subject to ongoing risk of harm.

The quality of assessments ranges from inadequate to good. In some cases, insufficient weight has been given to the child's history alongside existing risk factors. In others, children have been left for too long in situations where they have been neglected before decisive action is taken to protect them. Stepping down to early help or targeted services or closing a case where risk has not been reduced is common practice, including before some assessments are fully completed and before risk is adequately assessed. Diversity and the cultural needs of children and families are not consistently addressed in all assessments and plans.

Practice relating to identifying and responding to young people at risk of child sexual exploitation is inconsistent and some young people have been left in potentially exploitative situations for too long. Though practice is improving, when children go missing, return home interviews are not yet routinely undertaken. As a consequence, the local authority is unable to collate information and fully understand why children go missing or whether episodes where children have gone missing are linked to them being at risk of exploitation.

Although the number of early help assessments is increasing, their quality is variable. Services provided by children's centres are well regarded by parents, and sustained interventions by, for example, the Family Recovery project are leading to better identification of need and improved outcomes for some children and families.

Children living in private foster care arrangements are protected effectively. The

service is overseen and monitored by a named social worker. Responses to notifications and visits to children are timely.

Inspection findings

18. The experiences and progress of children who need help and protection are inadequate. Serious failings across the service have been identified as a result of this inspection, and these have left children at risk of harm and insufficiently protected. Inspectors identified a number of cases where the needs of children in need of help and protection were not being adequately assessed. This included 11 children referred to the local authority by inspectors because of the serious nature of the concerns, eight of whom were at immediate risk of significant harm. In the majority of these cases, children were left at risk of significant harm in unassessed situations. In all such cases identified by inspectors, the local authority took decisive action to intervene and protect children. During the inspection, management oversight was strengthened in the referral and assessment service, including the MASH service.

19. The application of thresholds for intervention and service provision and the recognition of risk were inadequate in a number of cases seen by inspectors. Referral pathways into the MASH service are clear and most referrals are allocated promptly to social workers. However, on too many occasions, managers and social workers have failed to recognise the need for an immediate section 47 child protection investigation. In some cases where risk has been identified, the response to assess and provide appropriate support and protection has not been swift enough. This includes cases where children have been at risk of sexual exploitation and where children have had unexplained injuries. Delays in visiting families and seeing children at risk have been as long as 10 and 12 days, and in one case 24 days, from the time of the referral. (Recommendation.)

20. Management oversight of casework is weak and lacks effective challenge. Case supervision varies in frequency and quality and in many cases it is ineffective in protecting children and proactively driving plans forward. Managers are insufficiently challenging and are overly optimistic in many cases. Action to protect children is not sufficiently decisive and results in delay and drift for some children. (Recommendation.)

21. It is common practice to consider stepping down or closing a case where risk has not been reduced and before assessments are fully completed and risk is adequately assessed. Assessments are concluded even though too little observation of and discussion with the parents/carers and children have taken place to gather the information required to ensure a full assessment of need and risk. (Recommendation.)

22. When risk is identified and a strategy discussion held, the strategy discussions do not comply with statutory guidance. In all cases seen, social care and the police were the only participants in the discussion. The resources and the skill mix of other professionals based within the MASH service are not used well enough to contribute to the overall decision-making process to safeguard children. This means decisions are based on incomplete information. (Recommendation.)

23. A current task and finish group, which is considering practice from strategy discussions to initial child protection conferences, recently identified that strategy discussions were not making the best use of the professional networks available in the MASH team. Despite this finding, there has been no corresponding improvement in practice. Internal audits undertaken in the first six months of 2015 judged most strategy discussions as good, indicating that audit activity is not yet robust enough in identifying deficits in practice and driving practice improvement. A strength-based learning review in March 2015 raised some concerns about practice, including delay and drift in some cases, but there is little evidence of learning to improve practice from this review. (Recommendation.)

24. The quality of assessments is too variable. Though inspectors did find adequate and good assessments, they also found cases where children's needs had not been adequately assessed. In poor assessments, there are significant delays in completing the assessments and addressing risk, no reviews are carried out, and the assessments are not updated following a major event in a child's life. Children's histories are not routinely considered and used to inform decisions being made about them. As a consequence, in too many cases, assessments are not thorough enough and result in further assessments being undertaken when cases are referred back to children's social care and re-opened. This creates delay and drift, which leaves some children living in difficult circumstances for too long before action is taken to protect them. (Recommendation.)

25. Direct work is undertaken with children, although this was not evident in all cases. Where practice is good, inspectors saw the effective use of big story books to help children understand their past experiences. Baking sessions and the three houses tool are used to ensure that children's voices are heard and to inform assessments and plans. Parents and children are now more engaged in initial child protection and review conferences, supported by an externally commissioned advocacy service. Two family centres provide good-quality parenting assessments where proceedings are being considered or have been initiated.

26. Child protection and child in need plans are poor. In most cases, plans do not focus on outcomes and do not set out clearly who will undertake an action within an agreed timescale. Children in need plans are not reviewed regularly enough and this leaves some children at potential risk of harm when more robust action is required to escalate concerns. Contingency planning for children is a weak area of practice. In most cases seen, the plan simply makes reference to convening a legal planning meeting should the child's circumstances not improve. This does not support families in understanding the serious consequences of their failure to protect their children. (Recommendation.)

27. Senior managers are effectively monitoring children on a child protection plan over 15 months. The local auhority reports that the number of children on longer-term plans has significantly reduced from 5.6% in August 2015 to the current figure of 0.7%. This ensures that children are not kept on plans indefinitely, and where plans are not helping to make sustained progress in the child's situation, alternative actions to protect children are rightly being considered. The proportion of children on repeat child protection plans – at 10.8% in October 2014 and 8.7% in October 2015 – remains well below the England average of 16.6%. The timeliness of child protection conferences and core groups is mostly good, with most held within statutory guidelines. Ninety-eight per cent of visits to children subject to a child protection plan are made within 15 working days. This is a significant improvement on 2014–15, when 74% of visits were completed within this timescale.

28. Delays in uploading case notes onto the electronic social care record (ESCR), in some cases for up to two months, mean information is not always readily available. On one occasion, a delay of 24 days from the time of the strategy discussion to the outcome of the discussion being available on the system left the social worker unclear about what action to take next in a particularly complex situation. The local authority acknowledges that there are data quality issues in children's specialist services. For example, while overall re-referral rates continue to remain relatively low at 18%, compared with the England average of 24%, inspectors noted that some cases were re-opened with a new assessment before the previous case had been properly closed down. Failure to close cases on the ESCR in a timely way will impact on the accuracy of the re-referral figures reported. (Recommendation.)

29. A range of specialist workers within the referral and assessment service provide consultation and advice to social workers on some complex case work, including child sexual exploitation, parental substance misuse and domestic abuse. Inspectors identified inconsistencies in the identification of and response to children at risk of child sexual exploitation, with some children experiencing inaccurate assessments of risk and insufficient protection. When concerns are identified accurately, social workers use a risk-based assessment tool to determine the level of risk and refer to the sexual exploitation multi-agency panel (SEMAP). The panel ensures that appropriate action is being taken to safeguard and promote the safety of the child referred. In a small number of cases, inspectors saw effective mapping exercises being completed by managers and social workers to identify risk, consider known hotspots in the area, make links to other children at risk and put strategies in place to protect children. (Recommendation.)

30. Management oversight of children missing from home requires improvement. A significant number of return home interviews have not been completed within timescales and in too many cases they have not taken place at all. An external organisation has recently been commissioned to undertake all return interviews relating to children living at home. As a result, this is an improving picture. The local authority currently does not collate or aggregate information provided in these interviews and so does not fully understand the root causes of absence or whether missing episodes are linked to children at risk of exploitation. (Recommendation.)

31. Diversity and cultural needs of children and families are not routinely addressed in assessments and plans. The local authority recognises that social workers need support and training to enable them to have more confidence in talking to children and families about their racial and cultural backgrounds. Where diversity and cultural needs are addressed in assessments and plans, it is done purposefully, enabling a better understanding of a child’s experiences.

32. The needs of disabled children living in the borough are met by a range of services and the disabled children’s team engages well with children and their families. There has been a recent lack of consistency in management oversight of this team and this is impacting on timeliness in the delivery of plans and in their review. The hospital-based service provides a service mainly for unborn babies and children with serious diseases attending the hospital. This is providing timely interventions, with some improved outcomes evident. The out-of-hours service provides a sufficient emergency response to children and their families who need a service outside of normal office hours, although the nature of its response is limited by having only one social worker on duty during each shift.

33. The Wandsworth Safeguarding Children Board (WSCB) held its annual conference in October 2014 on the subject of neglect. Before launching the neglect strategy in March 2015, it started to help practitioners consider the impact on children who are neglected. While the increase in children being placed on a plan as a result of neglect (currently 36%) cannot solely be attributed to the conference, raising awareness of the issue is having a positive impact on practitioners' practice across the partnership in responding to neglect. The increase in early help assessments (EHAs) is an example of where better identification of need means that children have the potential to receive help and support much earlier in their lives.

34. An early help hub and a family information service support practitioners and families in accessing information on a range of services that make up the local authority's early help offer. This is becoming increasingly effective. The early help IT system (EHITS), a secure web-based system for professionals to draft EHAs and for lead practitioners to share information, is enabling wider engagement across the partnership to support early intervention and prevention. Overall, the service has seen an increase in the number of EHAs supporting children and families, an increase in the number of professionals from partner agencies taking the lead in identifying the need for an EHA and an increase in the number of children receiving early intervention through targeted and specialist services. In March 2015, there were 2,849 open EHAs. Assessments, while variable in quality, are leading to more families and children receiving an early help service to support their needs.

35. There is more work to do to ensure that EHAs are completed appropriately. The signs of safety and well-being framework is used well in assessments to identify what is working well and what needs to be addressed. All the EHAs seen contained plans to tackle concerns; however, these varied in quality, with few containing specific and measurable targets. Almost none had clear timescales for actions to be completed by. The well-being and safety scale is not routinely completed. Progress and the impact of services provided are not effectively measured in review meetings, but a revised template has recently been introduced with the aim of improving the monitoring of outcomes for children and families. (Recommendation.)

36. Families in receipt of early help services told inspectors that they had been made to feel welcome and consequently felt less isolated in their community. They felt they had benefited from a wide range of support and advice, programmes and group activities to enable them to develop their parenting skills. They were able to give examples of practical and emotional skills they had developed that had helped them to care for their children. Service users from diverse ethnic backgrounds reported that they and their families had benefited from culturally sensitive support through early help services and local children's centres. This has enabled them to better integrate into the community and to understand and accommodate social norms that differ from their own cultural upbringing.

37. The local authority provides a range of effective services to support victims and survivors of domestic violence and abuse, including mental health provision and housing services. Multi-agency risk assessment conference (MARAC) arrangements are satisfactory. They appropriately consider all cases of high-risk domestic violence.

38. The number of children missing education has significantly reduced from previous years, with an increased number being placed in school within a shorter time. Secure processes are in place to monitor those children missing education, with the local authority assuring itself that a suitable school place has been confirmed before ceasing its monitoring. Effective networking across schools and partner organisations supports the prompt placing of vulnerable children in schools. There are few instances where a child is taken off roll by a school. Where this does occur, the local authority challenges headteachers appropriately. There are currently no looked after children missing education and, where such an instance arises, an education welfare officer takes swift action.

39. Innovative and effective responses, such as the Wandsworth Interim School Project (WISP), enable secondary pupils new to the area to be educated temporarily while a permanent school place is arranged. Good work is taking place to explore the links between persistent pupil absences and, for example, potential child sexual exploitation, with the aim of sharing information with schools and taking action.

40. A well-established anti-bullying and e-safety programme supports the practice of front-line staff in keeping children safe. It involves appropriate external organisations such as community safety. The programme has been successful and its reach is being extended to further education, initial teacher education and early years settings.

41. The response to 16- to 17-year-old young people presenting as homeless is variable. In some cases, efforts to engage young people and their families in mediation work to enable them to return home were evident, and in others, young people were appropriately accommodated under section 20 of the Children Act 1989. However, in a small number of cases, there was inappropriate use of bed and breakfast accommodation without it being clear how these young people were being safeguarded in such accommodation. This accommodation is not suitable for a young person.

42. Children living in private fostering arrangements are safeguarded effectively. There are currently seven private arrangements in place. Cases seen showed that good outcomes are being achieved for children with effective oversight of the service by one dedicated worker. Raising awareness of private fostering is a significant aspect of a social worker's role, including within hard-to-reach communities. Social workers have been successful in reaching the Somali community through attending the Somali family network group. Leaflets are printed in a number of languages and distributed to target areas to support early identification of children living in private arrangements. Responses to notifications and visits to children are appropriate and in line with the national minimum standards for private fostering arrangements.

43. Responsibilities for the designated officer role and the investigation into concerns about adults who care for and work with children are currently shared between IROs and child protection conference chairs on a daily rota. These arrangements have the potential to lead to inconsistency in the application of thresholds and decision making. Senior manager oversight helps to ensure consistency in these areas and a review is underway, which is considering capacity and management oversight of the service. Cases seen during the inspection evidenced that children are appropriately safeguarded through the designated officer process.

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

Summary

Children only become looked after when it is in their best interests, but not all assessments take sufficient account of the child's history or show sufficient engagement with children and families.

Provision for care leavers is inadequate as too many have been placed in bed and breakfast accommodation for long periods of time. Their safety and support needs have not been adequately assessed or provided for. The number of care leavers who are not in education, employment or training (NEET) is too high. The lack of clear routes to employment and training means that too few care leavers access available opportunities.

Not all plans for permanence are made with sufficient urgency. This leads to drift and delay for children waiting for a permanent home. Most plans are not specific enough. Managers and IROs do not scrutinise, challenge and oversee the plans effectively to ensure that they are kept on track. The lack of a permanence tracker to enable senior managers to oversee the plans exacerbates this situation.

Although still low when compared with the national average, the number of adoption decisions made by the agency decision maker has risen during the past year. A lack of direction and urgency in securing timely adoption has led to a service review and action plan for change. In key areas, such as family-finding and the timely recruitment of adopters, further improvements are needed.

The process for commissioning of placements is under developed and relies too much on the purchasing of individual placements, usually without planning and at short notice (spot purchasing). The recently developed sufficiency strategy focuses on fostering. It makes no reference to the current mismatch between approved adopters and children waiting, nor to its insufficient accommodation for care leavers with high needs. Placement matching processes are good and enhanced by the access to resources team's engagement with young people to discuss the most appropriate match. Support provided by the virtual school and the designated nurse for children looked after ensures that children placed outside the borough are not disadvantaged regarding their health and education needs.

Children feel listened to by their social workers and well supported by their carers. Foster carers are supported well by social workers and other professionals to maintain placements and receive training and mentoring to enhance their knowledge and skills.

Children at Key Stage 1 and 2 do well, making at least the expected rate of progress in their education. At Key Stage 4, outcomes are much weaker, with poor GCSE

results. Of this group, the majority have special educational needs. No child looked after is currently missing education, and absence rates are declining. However, personal education plans do not always provide children with a clear progression plan.

The placement support team is effective in offering a local child and adolescent mental health service (CAMHS) for children/young people who can self-refer, and this includes support for those young people out of the area. It provides an advisory service for other professionals and for carers. Post-permanence support is effective. Carers are given assistance to manage behaviour, maintain contact arrangements and sustain placements.

The children in care council, known as CLICK, is outstanding. Its participation in service development is well embedded and it acts as a source of support and advice to staff and their peers.

Inspection findings

44. Children and young people only become looked after when it is in their best interests. In most cases seen, risk was properly assessed. For a small minority, there were delays in taking action, leaving some children at home in situations where they were neglected. In most cases, children were visited swiftly following admission to care and children's views were well recorded.

45. Not all assessments are of good quality; therefore, they do not provide sufficient and accurate information to lead to robust plans. Inspectors saw some good assessments that covered historical and key factors and thorough exploration of risks and protective factors. Children and families were well engaged. In cases that were less good, there was inconsistent involvement of children and families, poor chronologies and lack of depth and clarity leading to poor-quality planning. (Recommendation.)

46. Clear improvements in home circumstances were not evident in most cases seen where children and young people have returned home. This is due to a lack of focus on what work has been completed with parents and how change will be sustained. In better cases, more effective work was evident. For example, in one case it was clear that the child's home situation had improved due to social work support to the disabled mother of a child, harnessing support from the extended family and regular involvement of a parenting worker and other support services. (Recommendation.)

47. The response to young people missing or at risk of child sexual exploitation is variable. In some cases, there is evidence of social workers making sustained efforts to engage young people in discussion about reducing risk. In these cases, risk assessment tools are used, with good liaison between carers and other professionals to address concerns, along with regular reviews at the sexual exploitation multi-agency panel (SEMAP). (Recommendation.)

48. More accurate reporting of missing from care episodes between April and November 2015 evidences 370 episodes of looked after children going missing, which is a sharp rise from the 89 reported during the same period in 2014. During June to November 2015, 30 children looked after had at least one missing episode. All 30 were reported to have been offered a return home interview and all but three accepted at least one interview. This has not been borne out in cases seen during the inspection, where very few independent interviews were seen on case records. It is therefore unclear how reliably return interviews are being offered and taking place and what use is made of the information gathered. (Recommendation.)

49. Plans are not sufficiently comprehensive in most cases to meet all aspects of children's needs. Using the signs of safety model, the concerns about children and what needs to happen to effect positive change are described well. However, the specific actions that need to be taken, who needs to take them and in what timescales are less well defined. In too many cases, children's immediate needs were well considered but longer-term plans such as achieving permanence were overlooked, resulting in drift and delay. (Recommendation.)

50. Permanence is not being achieved quickly enough in most cases seen due to delays in management decision-making and in the completion of assessments of children and carers. Managers' and IROs' oversight in these cases has been ineffective due to a lack of challenge and absence of timescales. Lack of management oversight has been compounded by the absence of a permanence tracker to provide senior managers with an overview of the children waiting for permanence and to enable them to monitor this effectively. (Recommendation.)

51. Although looked after children's second reviews make clear decisions regarding permanence, family-finding is not being driven forward with sufficient urgency. From the child's individual permanence tracker, it is possible to see the family-finding activity for each case with the use of local consortia, features in publications and local authority activity days. The recently developed early permanence planning panel shows good consideration of cases but does not set timescales for the activity required, which is left to individual workers' discretion. The local authority has been slow in developing a permanence strategy but now has a comprehensive document that reinforces the principles and processes of permanence planning, with a clearer focus on parallel planning.

52. As part of its children looked after service improvement plan, the local authority has recently introduced a multi-agency care and resources executive panel (CARE) to consider placement requests, placement options and support. This is too recent to evidence impact.

53. The local authority reports that 38 referrals were made between June and November for family group conferences and only five have not proceeded to conference. However, the local authority recognises that more needs to be done to embed this area of work as some connected person's assessments have been delayed due to the limited use of conferences in identifying family members.

54. The commissioning of placements is under developed, with an over-use of spot purchasing rather than collaborative agreements involving other neighbouring local authorities and independent providers. The local authority is working to strengthen its commissioning process with the introduction of some additional dedicated staff. It has recently developed a sufficiency strategy and has also undertaken a review of its fostering service to ensure that it has a sharper focus on recruitment, retention and support of carers. Currently, the local authority has insufficient foster carers to meet its needs and struggles to place older teenagers, sibling groups and children with complex needs. A focused recruitment drive has led to three new carers being approved this year, with six in assessment and five booked into preparation training. Although this is a promising start, it coincides with a review of all the local authority's foster carers and the loss of some long-standing carers. This has resulted in a net loss of 17 carers this year and the recruitment activity will need to be sustained in order to meet future demand. (Recommendation.)

55. The numbers of children experiencing three or more moves in 12 months has been worsening over recent years and at 31 March 2015 stood at 13.9%, which compares with the national average of 11%. Although long-term placement stability for children in placement for two or more years was below comparators in March 2015, at 60.3%, it has now improved to 69.6%. Improving placement stability has been identified as a priority and some early indicators of success have been seen in placement planning. For example, access to resources team (ART) members have met with young people to consider placements and share expectations to secure the best match for the young person. This, alongside improvements in introductions between young people and carers, is leading to improved matching.

56. The Children and Family Court Advisory and Support Service (Cafcass) and the local judge report that the quality of work presented to courts is good, with evidence and analysis provided by social workers who know the cases well. Applications to courts are timely, but the timescales of proceedings are outside local and national averages at 31 weeks. A legal tracker is in place to monitor cases through the court process. Cases seen in the Public Law Outline process show clear letters before proceedings, well-evidenced court statements and parenting assessments of very good quality.

57. Young people report that they see their social workers regularly and feel that they do a good job. Local authority data indicates that 94% of visits are currently within timescales. Social workers know the children well and there is evidence of some purposeful work with them, for example using a child's drawings of his superhero to discuss the positive qualities he could emulate. Young people are helped to understand their rights and responsibilities via information contained in the pledge and booklets about being in care.

58. Young people spoken with said they knew how to complain, and the number of complaints made by children, young people and their advocates rose from 55 in 2013–14 to 69 in 2014–15. Forty out of 69 complaints (62%) were upheld. An independent agency provides individual advocacy. In 2014–15, eight complaints were made using this service. Forty young people contacted the service during the year and 32 (80%) were assisted to resolve issues without a formal complaint being made.

59. During 2014–15, 92% of children looked after had an up-to-date annual health assessment, which is above the English average of 90%. Ninety-two per cent had up-to-date immunisations, which is also above the English average of 88%. Eighty-four per cent had had a dental check, which was just below the English average of 86%. Health assessments seen were of good quality, with detailed background histories recorded alongside child development and discussion of health needs and actions.

60. Children looked after are benefiting from a recently established service called Access, delivered through a partnership between the South West London and St George's Mental Health Trust and the local authority. This has improved: pathways to services; consistency in the application of thresholds; and waiting times for services. Two clinical psychologists are also based in the effective multi-disciplinary placement support team. They provide one-to-one therapeutic work with children and are involved in running a twice-weekly therapeutic network and consultation service for professionals, carers and young people who can self-refer. This team also offer services to children placed out of borough.

61. During the inspection, there were 118 children looked after of school age, the vast majority of whom (92%) attend good or outstanding schools. Educational outcomes for the very small cohort at Key Stages 1 and 2 are at, or above, national expectations for all children, with most making at least expected progress in reading, writing and mathematics. Key Stage 4 outcomes in 2014/15 were weaker, with those undertaking GCSEs performing below national comparators for children looked after. Of this group, 65% had special educational needs (SEN). The local authority has a good understanding of the educational needs of these pupils and takes action, often through the pupil premium grant, to improve their outcomes.

62. There has been a recent and rapid improvement in the work of the virtual school to provide a better quality service to young people, parents, carers and schools. Virtual school team members collaborate well with schools. Headteachers across the borough report favourably on the quality of support that they receive. Children looked after out of borough are afforded the same good level of support from the virtual school.

63. After a slightly delayed start in 2014, managers are ensuring that the pupil premium grant is increasingly well targeted to support interventions such as one-to-one support, enrichment and additional tuition. Guidance to schools usefully supports them in devising sharp, pupil-focused applications and ensuring that procedures are in place to monitor the impact of the grant. Academic results are not yet, however, reflecting these interventions.

64. A recent impetus on improving the quality of personal education plans (PEPs) has had some impact, but the plans lack consistency and sufficient management oversight. The PEP process often fails to link sufficiently with, for example, SEN reviews or school reports to enable young people to have a clear progression plan. In the better PEPs, targets were set with the child and gave clear guidance on how they could improve. Pupils' progress was clearly described and a structured plan with achievable, personalised targets was agreed. Pupils had a good grasp of what they needed to do to improve. In the poorer instances, PEPs carried no useful information, targets or progress records and key participants did not always attend PEP meetings. Children and young people looked after therefore do not benefit from a single comprehensive mechanism to enable them to improve their educational performance.

65. There are currently no children looked after who are missing education. Where such an instance arises, an education welfare officer takes swift action. Rates of persistent absence for children looked after continue to drop. Over the last three years, the improvement has been from 12.5% to 8.2%. Front-line staff and service managers are working well to reduce this even further. There has also been a decline in pupils in receipt of fewer than 25 hours' education, a drop of 33% since the previous year. Five children looked after currently receive fewer than 25 hours. Alternative provision is of good quality, is monitored effectively by the local authority and is quality assured in conjunction with neighbouring boroughs. The local authority uses this alternative provision appropriately for its own children to extend their hours in education. Where other providers are used for alternative provision, a member of the virtual school will visit, assess the suitability and initiate a PEP.

66. Children and young people placed out of borough do not appear disadvantaged. Where necessary, they are supported by the virtual school and the looked after children designated nurse. In cases seen, health, education, contact and all other needs were addressed. Children and young people living out of area are kept informed of the children in care council's CLICK groups and have access to activities. Young people living out of the area can join in meetings via Skype before attending an activity.

67. Young people speak positively about their placements with foster carers and mentioned good introductions to carers and their families. All young people said they feel part of the family and gave examples of carers helping with their education and supporting them in contact. One young person described her carer as 'amazing. I love her. She is like a mum'. Young people said that they knew why they were looked after and some had life story books and information regarding their family history.

68. Fostering assessments give a good overview of carers' backgrounds, history and parenting capacity, along with the type of child they will do best with. However, not all connected person's assessments demonstrate how carers will meet the individual needs of children. There are 23 approved in-house carers without an up-to-date Disclosure and Barring Service check due to a backlog with the London Metropolitan Police. The local authority has completed risk assessments and is putting in extra visits to these carers while the backlog is reduced, and is requesting checks earlier to avoid this lack of compliance with regulations.

69. Foster carers feel well supported by the placement support team, social workers and the virtual school. Examples of post-placement support seen during the inspection include assisting carers with behaviour management strategies, play therapy and supporting foster carers' own children in dealing with aggressive behaviour from a fostered child. Foster carers receive training and use support groups to enhance their knowledge and skills. Carers said that they know what they should do if children go missing, for example due to training, availability of written information or direct support from other professionals. In addition, all new carers receive mentoring for their first year from a more experienced carer.

70. Matching for permanent placements is well considered by the adoption and permanence panel, with effective scrutiny of how carers will meet the needs of young people. Recommendations to the agency decision maker are well recorded but it was not always clear how carers would meet the long-term needs of the children presented. The quality of special guardianship order (SGO) support plans seen were good and the service offered by the post-permanency support team shows effective working with carers. For example, it supported an SGO carer with contact and managed the ensuing questions of why the child could not live at home.

71. Children looked after reviews are occurring on time in 91% of cases, which is an improvement from the 2014–15 figure of 61%. Reviews provide evidence of thorough discussion regarding what is working well, what the worries are and what needs to happen. However, the plans arising from these reviews are not specific enough in many cases, focusing on a particular worry, such as education, and not on all future needs.

72. IROs encourage children and young people to participate in their reviews, using pictures and DVDs for disabled children and opportunities for young people to chair. Better contact with children between reviews is being developed with the help of CLICK in using social media. IROs have raised 27 practice alerts and 18 care planning alerts this year, which is a rise from 23 in total for 2014–15. However, the impact of these alerts is not clear as IROs could not identify the trends arising and how learning is informing future practice. An externally commissioned agency provides an advocacy service for children looked after and helps them secure constructive resolution of complaints.

73. The children in care council (CLICK) is outstanding in its participation with the local authority. There is ample evidence of CLICK being involved in service development, such as revamping the pledge for different age ranges, producing booklets for children and young people entering care, staff appointments, assistance with foster care recruitment and offering support to each other. The group meets regularly for work and play and their engagement throughout the service is evident.

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The graded judgement for adoption performance is that it requires improvement.

74. There has been a year-on-year reduction in the use of adoption from 16% (2012–13) to 8% (2013–14) to 6% (2014–15). The local authority has fewer children leaving care through adoption (an average of 10.5% for the period 2012 to 2015) than England (14%) and statistical neighbours (11%). The local authority has not been rigorous enough in ensuring that adoption is achieved for all children for whom it represents the best route to permanence. However, the number of children with an adoption plan has recently begun to rise, with 18 agency decision-maker decisions for adoption for the current year compared with a total of 10 for the previous year.

75. The local authority demonstrates determination in pursuing adoption for children who are harder to place. Of those adopted during 2014–15, 54.1% were from ethnic minority backgrounds, as compared with the 8% England average, and 13.5% were aged over five, as compared with the 5% England average. Of those currently placed for adoption: two are over the age of five, three are from ethnic minority backgrounds, and two are siblings.

76. For the nine children adopted during 2014–15, the average time between entering care and being placed for adoption is 519 days, which demonstrates an improvement for that 12-month period. However, the local authority acknowledges that for 2015–16 the number of days will be higher. For these children, timeliness is adversely affected by the complexity of their needs or by delays relating to inter-country adoption. The local authority understands these children and the reasons for delay well and is taking appropriate action to secure them with permanent homes.

77. In the three-year period 2011–14, the average time between a local authority receiving court authority to place a child and then deciding on a match was 254 days. The local authority reports that this slightly improved during the three-year period 2012–15 to 224 days (unpublished scorecard data). In the three-year period 2011–14, the average number of days between entering care and being placed for adoption was well above the national average and the government target. Although timeliness is improving, it is not improving enough to keep up with the reducing government target.

78. The adoption service has experienced a number of changes, including lack of consistent management oversight and the loss of experienced staff. These have impacted on the timeliness and quality of services for children and adopters. A lack of management direction has led to connected person's assessments becoming a priority for the service. This has resulted in a corresponding lack of capacity and focus on adoption. A statement of purpose is in place but this is out of date. Current tracking mechanisms are in place for individual children, which evidence the family-finding activity undertaken, but they provide too much detail, rather than focusing on key milestones in the child's journey. There is a lack of basic data for managers, such as timeliness of adopter assessments. These factors have led to a lack of urgency and drive in securing permanence for children through adoption.

79. The local authority has more recently recognised the need to sharpen its focus on adoption, and a recent adoption review identified a number of areas that required improvement. A comprehensive action plan is in place, set against each of the key recommendations. A review of the adoption panel membership, the development and launch of a permanence strategy and an adoption recruitment strategy are now in place. A tracker to assist senior managers to monitor the delivery of permanence plans is under development. Although the number of children with an adoption plan is increasing, improvements in timeliness are not yet clearly evident for children and families.

80. Family-finding only starts once a placement order is granted, which is not early enough. There is no dedicated resource for family-finding and no uniform process followed by the whole service, and so the process relies too much on individual workers' discretion. There is, however, effective use made of the regional consortium, voluntary agencies and activity days. There are currently 23 children with an adoption plan agreed by the agency decision maker, of whom 15 are the subject of a placement order. However, of these, only one child is linked and this reflects the lack of drive to identify and secure placements. When a prospective match is identified, formal meetings, including with prospective adopters, lead to carefully considered matching and plans of introduction.

81. An adoption recruitment strategy is now in place to specifically target adopters to meet the profile of children currently waiting for adoption. The local authority has refreshed its website and made links with faith and community groups. However, the strategy is still in its infancy and has not yet impacted on front-line practice. There are currently 15 households approved, with nine currently linked to a child. Although the strategy identifies the need for adopters for sibling groups, school-age children and children from ethnic minority backgrounds, recent approvals have not enabled any new matches to be made. This means that matches will have to be identified from other sources, creating further delay. Adopters wait too long from approval to matching, with 91% (2011–14) waiting more than three months between approvals and matching. This is well above the statistical neighbour and England averages of 59% and 58%.

82. Adopters are recruited from a wide range of backgrounds. However, not all routes of permanence are fully explored with them, for example fostering to adopt and concurrent placements are underdeveloped. There is currently only one child benefiting from a foster to adopt placement, which is a spot purchased placement. This is a missed opportunity to provide consistency of care for children and to reduce the number of changes in placements that children experience.

83. The adoption and permanence panel chair is suitably qualified and appropriately experienced for this role. There is a central list of panel members with a broad range of professional backgrounds. Some members, including the chair, have been on the panel for a long time. A fixed term of office is now in place to refresh the membership to ensure that it better reflects the community. The level of debate, questioning and decision making from the panel is appropriate, with well-considered matching. Assessments referred to panel are variable in quality and not always completed within timescales. Prospective adopter reports do not always reflect the key skills of potential adopters and how these impact on their parenting ability. Some child permanence reports (CPRs) were unhelpfully critical of birth parents, but inspectors also saw evidence of some good-quality CPRs that gave a sense of the child’s journey and identified their specific needs.

84. There is no adoption panel annual report, but the chair produces quarterly reports that detail the panel’s activity and identify practice issues. Senior managers in the local authority receive these but there is no comprehensive overview of the year’s activity or analysis of trends to improve services to children and families.

85. Life story work and later life letters seen were generally of good quality. These were comprehensive and sensitively written and would help children understand their pasts. Cartoons are used creatively to explain to children difficult issues in a child-friendly manner.

86. Post-permanence support is a clear strength. Children and families can access adoption support throughout their childhood and beyond through the post-permanent support services. Adopters value the broad range of support that they receive, including assessments to support family therapy, enhanced adoptive parenting courses and support in helping children understand their pasts. There are currently 282 children receiving linked support and advice services, with 83 families receiving direct contact and support, including promotion of contact with birth families. The number of adoption disruptions is low: none during 2014–15 and one in the current year.

The graded judgement about the experiences and progress of care leavers is that it is inadequate

87. The local authority has failed to ensure that there is sufficient suitable and safe accommodation to meet the needs of care leavers. During the past year, the authority has placed 10 care leavers in bed and breakfast accommodation for periods of time ranging from four to 34 weeks. At the time of the inspection, there were four care leavers in bed and breakfast accommodation, two of whom had been in such accommodation for almost six months. Risk assessments have not taken place, nor have the young people's pathway plans been reviewed to address their change in circumstances. This has resulted in an absence of comprehensive support plans to ensure their well-being. (Recommendation.)

88. The local authority reports that 90% of all care leavers and 83% of care leavers aged 18, 19 and 20 are in suitable accommodation. The local authority relies too much on semi-supported and independent accommodation. There is a lack of accommodation for care leavers with high support needs. Some young people spoken to by inspectors indicated that they had been placed into independent accommodation before they were ready, and therefore had struggled to maintain their tenancies. The local authority does run an eight-week independence preparation group three times a year. It also runs monthly groups for care leavers, where the young people choose the topic discussed. However, there needs to be a greater focus on preparing young people with the key skills necessary for successful independent living.

89. Though 11 care leavers are in Staying Put arrangements, the numbers placed with in-house foster carers are very low (four). There is a Staying Put policy in place, with foster carers having been clearly consulted on its implementation. However, this arrangement is not embedded sufficiently within in-house provision to enable more young people to take advantage of this provision to facilitate their journey to independence. The local authority has recognised that it needs to increase the numbers of care leavers in such arrangements to enable greater stability in their transition to adulthood.

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90. The quality and timeliness of pathway planning are variable. Pathway plans have not always had SMART targets to identify progress to be made. In a number of cases they are completed without young people's engagement. The local authority has identified the need to improve pathway planning and has moved from the pathway plan being located within the updated assessment record to being a standalone document. This has helped improve young people's engagement with the planning process as well as improve the quality and timeliness of the pathway plans. The local authority is now reporting that 90% of care leavers have an up-to-date pathway plan compared with 67% earlier in the year. However, pathway plans are not reviewed when young people's circumstances and needs change, which means that they are not then effectively supported. (Recommendation.)

91. The local authority is currently supporting 29 young people at various stages of their university career. For the year 2014–15, 15% of care leavers moved into higher education, a greater proportion either than statistical neighbours or nationally. The proportion in employment or training (16%) and those who were NEET (44%) was, however, worse than both statistical and national comparators. Figures from the local authority for the current year (2015–16) indicate a similar picture. There is insufficient involvement of the local authority as a corporate parent in offering employment, training and development opportunities within the council. Nor is there a comprehensive multi-agency skills and apprenticeship strategy with clear routes to employment and training for young people. (Recommendation.)

92. A recent review has led to more personal adviser time being dedicated to supporting vulnerable care leavers. Those young people who are engaged with their personal advisers receive good support to develop their aspirations, with a focus on directing them towards constructive activities such as volunteering or sport. The impact of these efforts on educational and vocational outcomes is still not sufficient.

93. Most young people have a copy of their health passport. This gives information relating to a young person's health history and about relevant community health provision. Inspectors saw evidence of efforts to address young people's health needs through their pathway plan and of referrals being made to appropriate adult services. A dedicated mental health worker has been appointed to work exclusively with care leavers, starting in January 2016. This will enhance the accessibility and provision of input around emotional health.

94. The local authority reports that it is in contact with a high proportion of care leavers (over 90%) but is currently not in contact with eight despite efforts made by the local authority to maintain contact.

95. Most care leavers spoke of an improving service and spoke positively of the availability and level of support they received from their personal advisers. Several examples were given by young people of where their personal advisers had made a difference for them. Young people in custody are receiving appropriate levels of support and the leaving care service and the youth offending service work well together to support young people when released.

96. Participation is a strength within the service. Young people talk positively about the role of the participation worker and about their role in reviewing the pledge and meeting with elected members. During the inspection, positive examples of young people contributing to the improvement of the service were seen, for example participation in appointments to senior managers' posts and in training and development programmes for staff and foster carers.

97. A care leavers' information pack has been developed by the local authority in collaboration with young people. This includes information about what children and young people are entitled to. However, there is no system in place to confirm that this has been received. As a consequence, some young people spoken to by inspectors were not aware of all their entitlements. The local authority has recognised the need to increase its use of information technology to increase the accessibility of relevant information.

98. The leaving care service improvement plan, established in October 2015, covers all the major areas where improvement is necessary, such as better monitoring of pathway plans. Some of the actions of the plan have been implemented, such as increasing the management capacity of the service, strengthening emotional health provision and ensuring more vigorous oversight of the contract with the commissioned provider. Overall, however, it is too early to evidence any sustained impact in the crucial areas of education, employment and training provision and the range of safe and suitable accommodation.

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Leadership, management and governance	**Inadequate**

Summary

Leadership, management and governance are inadequate. Lack of effective scrutiny by senior leaders, elected members and managers at all levels that they were not aware of the serious deficits in practice for too many vulnerable children until this inspection. Sufficiently robust management oversight is not in place for those in need of help and protection. This means that risks to children and young people are not always identified.

Weak management oversight has led to poor practice not being challenged and children's needs not being met. Social workers feel supported by their line managers and caseloads are low, but this is not leading to consistent compliance with basic social work practice.

There are fundamental gaps in performance information central to ensuring effective scrutiny by senior leaders of safe front-line practice. Improvement in the quality and regularity of supervision, while a priority improvement area identified by local authority's own audit activity, remains insufficient.

When the local authority was informed of children potentially at risk of harm, it took swift and determined action to safeguard them. Throughout the inspection, the local authority demonstrated a clear commitment to addressing the weaknesses identified by the inspection.

Although the local authority has a variety of strategic strengths and clear accountability structures are in place, it has yet to set up a corporate parenting board dedicated to and accountable for improving outcomes for children looked after and care leavers. As a result of insufficient suitable accommodation being commissioned, too many care leavers live in bed and breakfast accommodation for extended periods of time. Lack of focus and timeliness has meant that children wait too long for permanent placements.

Partnership arrangements to protect children at risk of child sexual exploitation are well established strategically and operationally via the sexually exploited multi-agency panel (SEMAP). These are not consistently underpinned by robust practice. More work is required to ensure that all sexually exploited children are effectively protected. Children missing from home and care are not routinely interviewed on their return. When return interviews do not take place, risks can remain unexplored.

Leaders and managers place a strong emphasis on user participation, and the views of children and young people are secured and understood. The virtual school monitors the education of looked after children and has been effective in improving educational attainment and outcomes for children and young people with complex needs.

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Links to the Health and Wellbeing Board (HWBB) and Local Safeguarding Children Board (LSCB) are strong. Senior leaders take an active role, resulting in sharply focused priorities effectively targeted to meet the needs of local children.

Inspection findings

99. The local authority self-assessment, dated June 2015 and completed in anticipation of this inspection, assessed most services as good. This is inaccurate. During the inspection, the local authority revised its position and took swift action to remedy the poor practice identified with regard to some children. Nevertheless, it is concerning that managers at all levels were not aware of the serious and significant unsafe practice for too many children until this inspection.

100. An externally commissioned 'test of assurance' in 2014 concluded that the local authority has undertaken a thoughtful and well-planned approach to combining previously separate adult and children's statutory departments. A thorough end-to-end review conducted by the Chief Executive and the Director of Children's Services of services for vulnerable children and adults has provided a clear vision for service improvement. However, during this transition period, senior, middle and front-line management has not been sufficiently rigorous in challenging and monitoring the quality of services being provided to vulnerable children.

101. Widespread weak management oversight and decision making has led to a lack of compliance with basic social work practice in key areas. Improvement in the quality and regularity of supervision, while a priority area identified by the local authority's own audit activity, remains insufficient; it does not consistently accord with current policy. While the majority of social workers have low caseloads and receive regular supervision, there is both a lack of management direction and a failure to consistently challenge poor practice. This leads to delays in effectively progressing work for some children, which has left them at risk of harm. For example, in the majority of poor practice cases identified by inspectors and referred to the Director of Children's Services during the inspection, action was required by the local authority to ensure that children were appropriately safeguarded. The action taken regarding individual children was immediate and thorough. Action was also taken to strengthen management oversight in the referral and assessment service and to undertake an audit of recently closed cases. This led to 15% of the cases audited being reopened for further assessment. (Recommendation)

102. The vulnerable children's overview group (VCOG), which is accountable for ensuring that the local authority's corporate parenting panel responsibilities are met, is ineffective and lacks focus. While the lead member and senior officers aspire to provide high-quality services for vulnerable children living in the borough, the current approach is fragmented. The recently established corporate parenting panel is advisory and can only make recommendations to the VCOG. It cannot therefore drive improved outcomes for children looked after and care leavers. This lack of a dedicated and accountable strategic group has left the inconsistency in the quality of service delivery unchallenged. A lack of critical enquiry and ineffective monitoring has meant that care leavers with significant needs have lived for extended periods of time in unsuitable accommodation. (Recommendation.)

103. At a strategic level, the local authority has a comprehensive suite of widely distributed performance data being used effectively in some areas to drive up practice. For example, the timeliness of initial case conferences has risen from 42% in 2013–14 to 95% in 2014–15. In addition, managers have access to weekly performance information but do not use it to ensure that children are being effectively protected. Nevertheless, inspectors found significant gaps in fundamental performance information, which if available would have alerted senior leaders and elected members to the fact that managers and social workers were not fully compliant with the local authority's basic social work practice standards. More work is needed to ensure that the electronic social care record consists of accurate and up-to-date information. (Recommendation.)

104. Audit activity has not led to timely improvement. For example, an externally commissioned strength-based learning review in March 2015 identified concerns about quality and timeliness of assessments; variability in how regularly they are carried out; the impact of supervision of staff across services; and concerns about quality of performance in driving up standards. Actions from this audit had not been fully addressed at the time of the inspection. Internal case audits are not demonstrating rigour in judgements about the quality of work carried out. In contrast, although the local authority did identify some variability in quality, the audits for the purpose of this inspection were more robust. Inspectors agreed with 80% of the local authority judgements and where deficits in practice were found, appropriate action has been taken to ensure that children's needs are met. (Recommendation.)

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105. Working arrangements between the chair of the Local Safeguarding Children Board, Director of Children's Services and Chief Executive are in line with statutory guidance and are subject to appropriate and formal governance protocols, so officers are held to account. The joint strategic needs analysis (JSNA) has a strong focus on the needs of children and young people so that local needs are known and priorities shared and understood. The children and young people's plan (2012–15) has been superseded by the departmental business plan, first introduced in April 2014. This emphasises the key role effective partnerships play in developing and improving services.

106. Links to the Health and Wellbeing Board (HWBB) are strong, with senior leaders taking an active role, resulting in sharply focused priorities being targeted effectively to meet the needs of children and families. This ensures a joined-up and aligned approach to commissioning services, which is informed by the Healthy Child programme, the JSNA and Local Safeguarding Children Board priorities. For example, joined-up working with the clinical commissioning group has led to a coherent and well-received health offer to schools. A review of the CAMHS has led to improved access to the service.

107. A review of how children's services are commissioned is building capacity by creating three new posts dedicated to improving commissioning and contracting activity. The local authority has a range of effective commissioning partnerships meeting the needs of local children. For example, the local authority is a member of the South London SEN Commissioning Partnership of 10 local authorities, which work together on the commissioning of placements in independent non-maintained special schools and independent specialist colleges. Nevertheless, the local authority recognises that improvements are required in securing suitable accommodation for care leavers and in securing placement choice and timely permanent homes for children looked after. (Recommendation.)

108. Partnership working to protect children at risk of child sexual exploitation is established. The response to learning from the Jay Report (2014) concerning child sexual exploitation in Rotherham was swift. This included bespoke training for a number of departments, including housing and accident and emergency departments, and raising awareness in schools. Presentations to elected members has built on the police-led 'Operation Make-safe'. They have included visits to hotels and taxi companies on a rolling programme. There is online training on awareness of child sexual abuse and G-Mapping groups.

109. The strategic and operational sexual exploitation multi-agency panel (SEMAP) arrangements are well embedded and this is a strength. Senior managers in social care, the police and education understand the nature and extent of local issues. They have identified and targeted 'hot spots' and have systems in place to evaluate and monitor risk. Referral pathways to SEMAP are clear. However, the quality of practice with children suffering or at risk of sexual exploitation is not yet consistently good. Inspectors identified significant concerns in relation to some children who met the threshold for child protection where procedures were not followed. This meant a small minority of children were left without the appropriate level of support and care. (Recommendation.)

110. The police systematically refer all episodes of children going missing to the multi-agency safeguarding hub (MASH). This is analysed and a weekly report is provided. Although improving, when children return after going missing, return interviews are not completed promptly enough and information from interviews is not collated to identify pattern and trends. The local authority has recently commissioned a voluntary agency to carry out independent interviews when children reported missing return home and has plans to extend this service to children in care. The local authority has secure processes to record the location and status of all children missing from education. Monitoring arrangements are effective, for example if a child in care is missing, the education welfare officer makes contact on the first day of absence and takes appropriate actions. (Recommendation.)

111. Leaders and managers place a strong emphasis on user participation, and the views of children and young people are known and understood through surveys, casework, the Youth Council and the lead member's engagement with CLICK, the children in care council. The views of the children and young people are acted on and influence how services are delivered. Examples include their direct involvement in recruitment of school nurses and in the innovative 'Police U' think tank, which is helping to divert young people from criminal activity. The local authority has a strong commitment to responding appropriately to complaints from children, ensuring that they have support from independent advocates leading to a timely resolution of concerns. The lead member for children's services is experienced and committed and demonstrates a sound understanding of progress against current priorities, including child sexual exploitation.

112. The workforce strategy is effective and appropriately focused on developing and retaining strong front-line services. Turnover rates and the use of agency staff, at 16%, is lower than comparable boroughs. The appointment of a dedicated principal social worker is enhancing the profile of children's social work within the department. Staff are kept up to date with social work developments and best practice through a combination of face-to-face and online training, external courses and conferences and external award programmes. Staff and managers have easy access to training events via the online 'children's social care' portal. The content of the training programme is informed by appraisal outcomes and feedback from participants. It covers neglect, child sexual exploitation, children missing from home and care, the Prevent duty and female genital mutilation. It is a flexible programme and can be adjusted throughout the year as necessary.

113. A clear professional development framework is in place for newly qualified social workers' assessed and supported year in employment (ASYE). Good partnerships are in place with two local universities from whose social work courses they recruit into their ASYE scheme. A social work career pathway is also in place.

114. The borough is a Home Office Prevent priority area. The local authority has taken a wide-ranging multi-agency approach to developing and implementing its Prevent delivery plan. This is evidenced through its Workshop to Raise Awareness of Prevent (WRAP) training delivered to schools, further education colleges and youth services; work with community groups; and project work with young people. It has established a clear referral pathway for young people thought to be at risk of radicalisation that ensures that risk is assessed through the Channel panel and wider needs are addressed. This helps ensure the safety and well-being of young people.

115. The local authority has constructive relationships with Cafcass and the district judges, and attendance at the Family Justice Board is good. It is keen to liaise and it is 'well on board with the issues' when they meet. The local authority is efficient and organised in its applications to courts and works openly to address issues as they arise.

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The Local Safeguarding Children Board

The Local Safeguarding Children Board requires improvement

Executive summary

The Local Safeguarding Children Board (LSCB) in Wandsworth requires improvement to be good.

Wandsworth's LSCB complies with its statutory responsibilities and the requirements of the statutory guidance 'Working together to safeguard children' (2015). Partners are well engaged on the work of the Board, challenge each other constructively and hold each other to account. Safeguarding is appropriately prioritised by partners and well evidenced through section 11 audit reports.

Monitoring and oversight is rigorously undertaken by the Board through performance data analysis and audit. However, systematic analysis of the Board's key performance indicators has not been sustained over the past year.

Multi-agency and individual agency audits have been undertaken on behalf of the Board. However, repeat audits have not been completed, and significant areas of concern identified in a concurrent inspection of the local authority children's help and protection services had not been recognised by the Board.

Learning from serious case reviews and from child deaths is rigorously implemented through a process of dissemination, including learning events for partners.

The Board routinely oversees services to safeguard vulnerable young people, including those at risk of child sexual exploitation and those going missing. However, it has not ensured consistency of practice or aggregation of information on these young people to inform service development.

A wide range of multi-agency safeguarding training is provided and e-learning modules have recently been developed to enhance this. However, the impact of training is not yet sufficiently evaluated.

The Board has clear and appropriate priorities, incorporated into a realistic business plan.

Recommendations

116. Ensure that key performance indicators agreed by the Board are routinely collated, analysed and reported to partners, enabling them to evaluate the impact of multi-agency practice to safeguard children.

117. Ensure that multi-agency and individual agency audits of practice are regularly conducted to enable partners to evaluate the impact of safeguarding practice in each individual agency. Ensure that learning from audits is used to improve practice and fresh audits are undertaken to evaluate impact.

118. Effectively monitor and evaluate practice in relation to children at risk of child sexual exploitation and those who go missing. Ensure that there is appropriate challenge when deficits in practice or failings in the analysis of return interview outcomes are identified.

119. Effectively monitor and evaluate the application of safeguarding thresholds by partner agencies. Ensure that agencies are challenged appropriately when they do not consistently apply thresholds.

120. Ensure that the programme of multi-agency training is subject to long-term evaluation of its impact on practice and outcomes. Ensure that the assessment of training needs from agencies includes information from long-term evaluation to better enable the Board to commission future training.

Inspection findings – the Local Safeguarding Children Board

121. The LSCB complies with its statutory responsibilities as defined in 'Working Together to Safeguard Children' (2015). Governance arrangements between the Board and other strategic partnership boards are clear and well established. A joint protocol between the Health and Wellbeing Board, the Community Safety Partnership, the Safeguarding Adults Partnership Board (SAPB) and the Annual Review Partnership Forum clearly sets out the relationship between these groups. Many of the senior managers from partner agencies are members of a variety of these boards, which facilitates communication and ensures that children's issues are considered. Issues from these groups relevant to the Board are routinely discussed by the LSCB. Early in 2015, the Health and Wellbeing Board recognised that it had not ensured that children's issues were sufficiently considered in its programmes. It has now addressed this.

122. The long-standing chair of the LSCB has steadily steered the Board through significant changes over the past four years. She is tenacious and is well respected by colleagues from partner agencies. She appropriately raises issues, exerts challenge and enables partners to do so. The chair works closely with the local authority Chief Executive, the Director of Children's Services and the local authority's elected members to ensure that safeguarding children and adults is given the highest priority.

123. The Board is well attended and represented by all relevant partner agencies, who actively engage in its extensive work programme. The flat structure of the Board, with an executive, a full board network group and four sub-groups means that all its groups have challenging work programmes. This is efficiently administered through a small business unit.

124. The LSCB has not sufficiently monitored the effectiveness of core front-line practice to safeguard children. As a result, the significant concerns identified through the concurrent inspection of help and protection services in Wandsworth had not been recognised before this inspection. The Board has effectively monitored and evaluated the effectiveness of early help services. It has considered reports on the development and impact of early help support for a wide range of vulnerable children and families. It has provided robust critique and challenge, for example in relation to the completion of medicals for looked after children. (Recommendation.)

125. The LSCB has implemented a series of multi-agency audits, following a recommendation from a previous local serious case review (SCR). It has systematically undertaken themed audits, some based on issues arising from the SCR. In the past year, the LSCB has commissioned themed audits in relation to children missing from home and care, children looked after who have returned home and child sexual exploitation. Learning from these has been disseminated to staff and the community and incorporated into training events. Several multi-agency audits programmed for this year have been delayed, in part due to this inspection and also because of the capacity demands on partner agencies. While the findings of audits are reported to the Board and included in a tracked action plan, the Board recognises that it has not re-audited or undertaken other work to assure itself that the issues arising from the audits have been addressed or improved. For example, the LSCB undertook an audit of the MASH in 2014 and had planned to undertake a further audit from May 2015. However, this had not been completed at the time of this inspection due to capacity issues. As a result, the LSCB missed the opportunity to identify the significant concerns found in the concurrent inspection. (Recommendation.)

126. The LSCB has established a monitoring sub-committee, which rigorously interrogates reports on key safeguarding issues and performance information and analysis on behalf of the Board. This is underpinned by a working group tasked with developing and analysing key performance data from all the LSCB partner agencies. Throughout 2015, this working group has refined the extensive core performance data routinely gathered by the Board. It has also reduced the number of indicators to make them more manageable and better linked to the Board's priorities. These have recently been agreed by the LSCB executive, together with clear methods for partners to collate and analyse data. However, throughout 2015, while the Board has received extensive data and analysis in individual reports on the specific service areas it has reviewed, it has not received reports on the synthesised analysis of all its key performance information. This is now scheduled for early 2016.

127. The LSCB has ensured that safeguarding is a priority for all its partners, through an exemplary range of section 11 self-assessment audits. The format of these has enabled extensive engagement of agencies and practitioners, including close involvement from general practitioners. Learning from these was incorporated into an independent report and widely published. This has enabled the LSCB to help partners to improve their individual safeguarding practice and to identify some common areas that required improvement. These have been systematically addressed by the Board, for example to ensure that all staff and volunteers know who their safeguarding lead is and who to speak to if they have concerns. The Board has engaged extensively with the local community and has active lay and voluntary sector members. It has sought to better engage local faith sector groups and recognises that more needs to be done.

128. The Board has established and reviewed safeguarding policies and procedures. These are in line with pan-London procedures and incorporate signs of safety models of practice. Clear and detailed threshold procedures have been widely published and overall are well understood by partner agencies. These align well with partners' threshold and eligibility procedures, in particular for access to local children's social care services. However, these thresholds are not applied consistently within children's social care services and this had not been recognised by the LSCB before this inspection. (Recommendation.)

129. The LSCB routinely monitors services that support a wide range of vulnerable children and families. It has robustly monitored the safeguarding needs of looked after children, particularly those placed out of the area. It provided positive comment and challenge on reports, including a multi-agency themed audit on looked after children. The Board effectively monitors services to raise awareness of and prevent female genital mutilation; children privately fostered; children whose carers have mental health concerns; and those at risk of domestic or substance abuse. The Board has strategically overseen services to support children at risk of sexual exploitation and those missing from home, care and education, influencing the development of these and raising challenge where practice could be improved. However, despite challenge exerted by the chair, the LSCB has not sufficiently ensured that learning from return interviews for children missing is aggregated, nor has it identified the inconsistent practice in relation to children at risk of sexual exploitation. (Recommendation.)

130. The LSCB's child death overview panel (CDOP) is well established and is attended by relevant partners. It robustly fulfils its statutory functions. The number of child deaths for Wandsworth children in recent years is relatively low and these have been effectively considered by the panel. While no general themes have been identified from local cases, panel members are linked to pan-London CDOP groups and make good use of regional and national learning and research. Support for the bereaved families is routinely considered and the panel has appointed a bereavement worker to work directly with them or signpost them to other support services. A significant proportion of child deaths relate to children who live out of the area, who are taken to the local hospital. The panel has established close links with the hospital and ensures prompt communication with the family's home authority.

131. Learning from SCRs, internal management reviews and from multi-agency and individual agency audits is overseen by a sub-committee of the LSCB. Learning from the last SCR in the area, published in 2014, has been effectively disseminated and incorporated into learning events for partners. An internal management review conducted by the LSCB for an SCR commissioned by a neighbouring authority has been recently published by that authority. While monitoring of action plans is primarily the responsibility of the commissioning LSCB, the Wandsworth LSCB plans to monitor the recommendations of this SCR that pertain to agencies in Wandsworth.

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132. An extensive and appropriate range of multi-agency training has been developed and delivered on behalf of the LSCB. The sub-group overseeing this was, until recent months, not directly managed through the LSCB, and its membership is being refreshed. Training is provided in relation to the key priorities of the Board, using learning from case audits and internal management reviews. The programme includes core child protection work for different experience levels, and current national issues such as child sexual exploitation. The training programme has been particularly successful in engaging general practitioners. The programme is clearly linked to the learning and improvement framework established by the Board. Learning is delivered through traditional classroom-based events, learning events and conferences. Overall, these are well-attended, although some recent events have been cancelled due to lack of take-up. The LSCB has considered alternative methods of providing training and has recently introduced e-learning modules to enable safeguarding training to be more readily accessible. Initial take-up has been positive, but it is too early to assess how many have completed these courses.

133. The LSCB has recognised the need to improve its evaluation of the impact of training on improving practice and outcomes for children. Traditionally, it has used participants' self-reporting questionnaires, immediately following courses, which overall are positive. In the past year, the Board introduced self-reporting questionnaires from participants three months after the course; however, the response rate has been poor, despite the chair writing to all partners. The training sub-group has explored different methods of evaluating the impact of training, making use of learning across London and other LSCBs. It has recently commissioned an e-learning evaluation and impact model, but this has not yet been implemented so it is not possible to assess its impact. (Recommendation.)

134. The LSCB's annual report for 2014–15 provides a comprehensive and rigorous account of the work of the board and contribution of its partners to ensure that children are safeguarded. It describes in detail key areas that the board has overseen and reviews what the board has achieved in addressing its priority areas for the year. These include oversight of early help services to safeguard children; vulnerable young people, particularly those missing from home, care or education; young people involved in gangs; and those at risk of child sexual exploitation. The report does provide some analysis of the impact of the Board, for example in relation to the extensive activity by partner agencies to raise awareness and tackle concerns about female genital mutilation and domestic abuse, although members acknowledge that wider analysis of the impact of the Board could be strengthened.

135. The Board's business plan is detailed, specific and measurable. It is ambitious in the context of the relative size of the area, the capacity of the small business unit and the amount of time that the chair is commissioned to undertake her work. The Board has reviewed and developed appropriate priority areas for 2015–16 based on local and national safeguarding issues. These include improving ways of involving young people to inform LSCB development. The views of young people have been used well over recent years to influence the work of the Board, through engagement with a variety of groups representing young people in the area and through the use of questionnaires.

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Information about this inspection

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other, and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people, and their families. In addition, the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people who it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

Ofsted produces this report of the inspection of local authority functions and the review of the Local Safeguarding Children Board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

The inspection team consisted of seven of Her Majesty's Inspectors (HMI) from Ofsted.

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