London Borough of Lewisham

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

and

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

Inspection date: 26 October 2015 – 20 November 2015

Report published: 20 January 2016

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

Executive summary

Children's services in Lewisham require improvement to be good. While standards for children looked after have been maintained and those for care leavers have improved, those for children in need of early help and protection have deteriorated. The Executive Director of Children's Services, appointed in September 2015, has been quick to identify deficiencies in performance and processes. The senior management team undertook a self-assessment of the whole service to identify areas of concern and those of strength. As a result, the new senior management team has reached a realistic understanding of the challenges facing children's

[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.

services in Lewisham. Their priorities, shared with and supported by senior leaders, are to make sustainable changes and to retain the current skilled and child-centred workforce.

Creating a culture and environment to promote sustainable change is a priority for the new senior leadership team. An action plan has been developed that appropriately prioritises the activities necessary to address shortfalls. For example, a new information technology platform has been commissioned as a matter of urgency and planning is well advanced to ensure that the case file audit programme is risk-based, proportionate and effective in addressing deficiencies in practice. Child protection processes are also under review to ensure that they fully comply with guidance. Some changes in practice have already been made.

Prior to the appointments of the present Executive Director of Children and Young People's Services and Director of Children's Social Care, the senior leadership team went through a period of instability. This has created legacy issues within aspects of the services that have declined or are poorly coordinated, exemplified by the current early help offer. Corporately, the leadership and governance arrangements in Lewisham have not been robust, or sufficiently rigorous, in challenging, monitoring and driving social work practice to ensure that all services for children and young people are good. Senior managers do not understand the quality of services well enough because they do not consider a wide enough range of data.

Thresholds for those most urgently in need of protection are well understood by statutory agencies in the borough. This ensures, for the large majority of children requiring protection, that timely action is taken to recognise and reduce risk. The application of thresholds for children in need are less well understood as pathways are not embedded. The process to access social work services is overly complicated and the multi-agency safeguarding hub (MASH) adds complexity while not functioning well to filter unnecessary work. Planning for children in need is an area that requires improvement to ensure that desired outcomes are clear and that progress can be monitored and assessed. Robust systems to monitor the effectiveness of step-up and step-down arrangements between early help and children's social care are not currently in place.

Services for children looked after remain good, with almost all children and young people benefiting from stable and secure placements. Social work practice is effective in improving outcomes for children looked after. Effective leadership of the virtual school enables timely identification of children when their educational progress and attendance begins to give cause for concern. This helps the virtual school to intervene in a timely way to offer additional support to children and young people.

Adoption performance remains a strength and permanency planning is progressed with appropriate urgency and thoughtfulness. Children with a plan for adoption are well supported, as are prospective adopters and this promotes effective placement matching. Care leavers value the good service they receive and almost all are in touch with the local authority. Personal advisers provide consistent support and

guidance, and enable care leavers to plan effectively for their futures. Increasing numbers of care leavers are attending further and higher education, including universities.

Individual work with children and young people who are at risk of child sexual exploitation or have been missing from home or education is often effective in reducing risk. The local authority and its partners are, however, less effective in sharing information to work and plan strategically for these children and young people. This inhibits prevention and disruption work at borough level. Managers have reviewed arrangements to track children missing from education and those who are electively home educated. As a result, the local authority holds good information on these groups, including up-to-date numbers of children, and has a good understanding of the reasons for children missing education or being educated at home

Performance management and quality assurance processes are underdeveloped. They are based on unreliable data and do not always focus on services and areas of practice in greatest need of improvement. Learning from audits is limited by plans that are insufficiently specific, measurable and time-bound. Learning from complaints and from feedback from children, young people and their families is limited and not used fully to inform service improvement.

Commissioning arrangements are well established. Commissioned services are routinely monitored and systematically reviewed to ensure that they meet current and emerging needs.

Good attention is paid to the identity and diversity needs of children in every part of the service. For children looked after and those requiring permanence, it is a particular strength.

This executive summary should be read alongside the recommendations in the next section of this report.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates no children's homes.
- The last inspection of the local authority's safeguarding arrangements for the protection of children was in February 2012. The local authority was judged to be outstanding.
- The last inspection of the local authority's services for children looked after was in February 2012. The local authority was judged to be good.

Local leadership

- The Director of Children's Services has been in post since 1 September 2015.
- The chair of the Local Safeguarding Children Board has been in post since June 2011.

Children living in this area

- Approximately 67,000 children and young people under the age of 18 years live in Lewisham. This is 22.9% of the total population (291,933) in the area (ONS 2014 MYE)
- Approximately one in three of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 22.7% (the national average is 15.6%)
  - in secondary schools is 24% (the national average is 13.9%).
- Children and young people from minority ethnic groups account for 63.4% of all children living in the area, compared with 25% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Black/Black British African (15.70%), Black/Black British Caribbean (11.70%) and Other Black (8.3%).
- The proportion of children and young people with English as an additional language:
  - in primary schools is 33.4% (the national average is 19.4%)
  - in secondary schools is 27.2% (the national average is 15%)

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

- 170 languages are spoken by pupils attending Lewisham schools.

Child protection in this area

- At 26 October 2015, 1,254 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 1,417 at 31 March 2015.
- At 26 October 2015, 369 children and young people were the subject of a child protection plan. This is a reduction from 377 at 31 March 2015.
- At 26 October 2015, 18 children lived in a privately arranged fostering placement. This is a reduction from 31 at 31 March 2015.
- Since the last inspection, two serious incident notifications have been completed, one has been transferred to another local authority and one has been referred for consideration.

Children looked after in this area

- At 26 October 2015, the local authority is looking after 476 children (a rate of 71.3 per 10,000 children). This is a reduction from 486 (74.3 per 10,000 children) at 31 March 2015. Of this number:
  - 261 (or 54.8%) live outside the local authority area
  - 33 live in residential children's homes, of whom 90.9% live out of the authority area
  - six live in residential special schools[3], all of which are out of the authority area
  - 371 live with foster families, of whom 54.2% live out of the authority area
  - three live with parents, of whom none live out of the authority area
  - six are unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been 29 adoptions
  - 20 children and young people became subject of special guardianship orders
  - 264 children and young people ceased to be looked after, of whom 6.8% subsequently returned to be looked after
  - 68 children and young people ceased to be looked after and moved on to independent living
  - 23 children and young people ceased to be looked after and are now living in houses of multiple occupation.

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

Recommendations

1. Improve governance arrangements so that there is effective oversight, support and challenge of children's services by the local authority's Children and Young People's Select Committee and the Corporate Parenting Panel to drive and monitor service improvement.

2. Review processes within the duty team to ensure that systems to manage contacts and referrals, including domestic abuse notifications, are secure and enable social workers and other professionals to keep children and young people safe and protected, in a timely manner.

3. Ensure that a revised early help strategy is implemented so that early help is effectively targeted, coordinated and evaluated so that families receive appropriate support when need is first identified.

4. Take action to improve information and intelligence sharing across partners regarding children at risk of sexual exploitation and/or going missing and use this to improve prevention and disruption activity.

5. Improve performance management and information systems to ensure that managers at all levels have timely, relevant and accurate performance information to enable them to work effectively and deliver a consistently good service.

6. Monitor and evaluate the effectiveness of step-up and step-down arrangements between early help and children's social care to ensure that appropriate actions are taken to improve services.

7. Ensure that all plans for any child or young person receiving a service: focus on reducing risk; identify the needs of all children in the family; and are understood by parents and young people. Plans should be specific, measurable and time-bound.

8. Ensure that initial strategy discussions include relevant professionals to inform timely decision-making and planning in child protection investigations, as required by guidance.

9. Ensure that life story work is completed for those children and young people in long-term care who need to know and understand their life histories.

Summary for children and young people

- Since the previous inspection, leaders and managers have not maintained high standards in safeguarding and early help services. Services have remained good for children looked after and have improved for care leavers.
- Local councillors do not always make sure that services are working well for children and young people. Managers do not use information well enough to improve services for children and young people.
- The recently appointed Executive Director of Children and Young People's Services has very quickly recognised the things that need to be done to improve services, and has put in place good plans to make this happen.
- When children and young people begin to experience problems, they do not receive help quickly enough.
- In some cases, social workers do not gain a full enough picture of children's needs. This means that some children experience delays in getting the help that they need.
- When children are at immediate risk of harm, staff from the local authority make sure that they get the help and protection they need.
- Social workers, personal advisers and other staff are enthusiastic and committed to improving the lives of children and young people. When children and young people are found to need the help of a social worker, they know the children and young people they work with well.
- Social workers and managers do not always have a full enough picture of the reasons why children go missing or when they are vulnerable to sexual exploitation. This means that the risks to children are not always clear and makes planning to keep children safe more difficult.
- Children continue to live with their families whenever this is what is best for them.
- Social workers visit children looked after regularly. This helps to ensure their safety and that their needs are being met.
- Support for the mental health of children looked after is available but some children wait too long to receive the help that they need.
- Many children looked after make good progress in their education. There are few absences from school and no children are permanently excluded or missing education.
- Social workers and personal advisers maintain regular contact with care leavers. They offer good support to young people based on their individual needs and circumstances.
- Care leavers live in safe and suitable accommodation.
- Children who need adopting are found permanent homes that meet their needs well. After they are adopted, they get good help and support to maintain contact with parents and family members when this is in their best interests.

The experiences and progress of children who need help and protection	Requires improvement

Summary

The service for children needing help and protection in Lewisham requires improvement. Although some early help services are resulting in positive outcomes for children, these services are neither well-coordinated nor sufficiently targeted.

The duty system is unnecessarily complex, although children and young people at risk of immediate harm receive an effective and timely service. There is, however, variability in how other contacts are dealt with. Few progress to referral stage and most are directed as contacts to early help services.

As a result of the way contacts are recorded, it is not always easy to fully capture and understand children's social care involvements. In some cases, this leads to delay in responding to need. The current duty configuration means the multi-agency safeguarding hub (MASH) adds complexity to the process rather than simplifying decision-making and information-sharing.

Strategy discussions are generally held within appropriate timescales, although it is an omission that health professionals and other partner agencies are not routinely invited to share information and contribute to planning. Risk is appropriately identified and addressed; however, child protection plans are often too detailed, making it difficult to pick out the key issues to be addressed. Assessments are variable in quality but the vast majority are adequate or good. Some creative direct work allows children to share their wishes and feelings with professionals. Social workers know the children whom they work with well.

The local authority's response to children who go missing and those at risk of child sexual exploitation, although inconsistent, is protecting children and young people. Return home interviews are not conducted routinely. When they are, they identify issues that led to the missing episode but these are not collated to build up a picture of the young person's needs overall, or the cohort of young people as a whole. The needs of children who are missing education are well understood, and proactive work ensures that they are located and supported to return to school.

The children with complex needs team provides a comprehensive range of universal and specialist services, which means that disabled children and their families receive integrated support at the point of need. The family intervention project (FIP) provides effective support to families and is the key element of the authority's response to troubled families and those on the edge of care.

Inspection findings

10. Although there are good examples of early help services that are valued by families, their effectiveness is not being tracked by the local authority. This

lack of monitoring means that the local authority does not know how many families are receiving these services, nor what impact they are having. In turn, this means that they cannot know whether individual children and families are receiving the right help at the right time. The early intervention service has recently been reconfigured following a restructuring of services, but it is too soon to assess the impact of these changes. Some early help services are directly commissioned by the local authority, for example children's centres and targeted family support. These services are quality-assured through contract monitoring arrangements and there is therefore a better understanding of these services and their positive impact.

11. Work is taking place using Team Around the Child (TAC) and Common Assessments Framework (CAF) processes, although there is insufficient performance data available to measure the quality, quantity or impact of these. The quality of CAFs considered by inspectors was variable. While the early help operational procedure requires a TAC to have taken place prior to contacting social care, in all but urgent cases, this had not occurred. This indicates that partners are unclear about the referral pathways.

12. Cases that do not meet the threshold for children's social care where an early help intervention is recommended are not routinely tracked. Several cases were seen where the recommendation had been that a TAC be convened but this had not happened. Families were therefore not receiving a coordinated multi-agency response, although it had been judged that this may be helpful to them. Children's social care do not check that a TAC has taken place. As a result, in too many cases a further contact was made to children's social care within a relatively short space of time as early help work had not been progressed.

13. The front-door duty social work system is unnecessarily complex; however, during the course of the inspection, no children were seen who were left at immediate risk of significant harm. Decision-making is generally both timely and appropriate in identifying risk. The current system relies on individuals' working practices rather than being underpinned by clear and sound processes and procedures. The committed and experienced staff in these teams work well and in a child-centred manner to keep children and young people safe.

14. The Multi-Agency Safeguarding Hub (MASH) does not operate as the first point of contact and does not undertake agency checks on all contacts. Consent from parents was evident in some case files, though is not routinely sought before agency checks take place. Too many contacts are received from the police that require no further action, although the processes to decide on appropriate actions in these cases are unnecessarily cumbersome and time-consuming. These factors highlight the need for the review of all 'front door' arrangements and thresholds currently being undertaken by the Local Safeguarding Children Board.

15. Contacts generally become referrals only when they require a social work assessment. This means that a considerable amount of work and information-gathering may be undertaken prior to a contact being accepted as a referral. This could include agency checks and work undertaken by the missing person liaison officer and the independent domestic violence adviser. In some cases, this causes delay in the appropriate provision or signposting of services. The true number of re-referrals is masked by this practice, as it is unlikely to be comparable in process to many other local authorities. It also means that it can be difficult to identify from the referral history those contacts that involved providing information and those where there were more immediate concerns. In some cases seen, there were delays in grasping ongoing issues because the history had not been fully taken into consideration, although no children were found who were at risk of immediate harm as a result.

16. Children who are at immediate risk of significant harm are well protected and urgent action is taken to ensure that they are safe. Child protection enquiries are managed well, and suitably qualified and experienced social workers conduct these. Similarly, in the vast majority of cases seen, the police are involved appropriately. Almost all strategy discussions involve a phone conversation with the police. It is an omission that the local authority does not routinely consider including health and other relevant agencies in these discussions where appropriate, for example midwives for concerns regarding unborn babies. In this regard the local authority is not compliant with *Working Together*.

17. The emergency duty service prioritises children's cases and communicates well with day services to safeguard children and young people. The emergency duty team has access to 24-hour legal advice. The team's limited capacity occasionally leads to a delayed response in a small number of cases. Children made subject to police protection out of hours are routinely placed with carers by police officers due to the lack of social worker availability.

18. In cases where the risk of harm is less immediate, most children and young people receive a prompt enough response. In some cases of pre-birth assessments, there were avoidable delays in convening an initial child protection conference (ICPC). This meant that for these children there were delays between concerns being raised and the development of a multi-agency child protection plan. Concerns are somewhat mitigated by evidence that the assessment was seen as part of a support process and appropriate services were put in place during the assessment process.

19. During assessments and interventions, children are routinely seen alone and their views are gathered using a variety of methods. Inspectors saw some creative use of direct work that ensured that children were able to express their feelings, and to understand what was happening in their lives. The views of children influence what is happening to them, and they are mostly reflected within the records.

20. Social workers are enthusiastic and committed to improving outcomes for children. They know the children with whom they work well and understand their histories, the impact of parental behaviour and the presenting risks and protective factors. This is not always fully reflected in assessment documents. Risks and impact relating to domestic abuse, parental mental ill-health or substance abuse are understood and addressed. Chronologies are not routinely used well within assessments to identify key issues or incidents in a child's life.

21. Families who have no recourse to public funds receive a good service from a dedicated team, which allows the necessary expertise in immigration law, family support and housing to be harnessed into a single service structure. For other children in need, the absence of formal structures to review child in need plans means that it is difficult to see how coordinated provision of preventative services is leading to positive outcomes for children. Nevertheless, it was evident in the cases tracked by inspectors that outcomes had generally improved for these children.

22. A functional multi-agency risk assessment conference (MARAC) arrangement is in place for families experiencing domestic violence. A social worker from the duty referral and assessment team attends the MARAC and gives information as appropriate, although consistently good case recording does not support this. It is not therefore always apparent from the child's file that there has been previous contact with partners in the MARAC. It is also not always clear what current or previous contact has taken place with families, making it difficult for the attending social worker to be fully aware of all risks to children from their parents' violent behaviour.

23. Decisions made by child protection conferences are appropriate, although they are not always held within prescribed timescales, and performance in relation to this has recently dipped. Attendance from health partners is good, although conference chairs report poor input from adult mental health and substance misuse partners. Given the high number of cases where these factors represent the presenting risks, this is of concern. There is no minute-taker at review child protection conferences, so the chair is required to take notes and provide a written summary. Chairs report that they are therefore unable to fully use their skills to develop solutions to risk as they are engaged in note-taking.

24. Child in need and child protection plans address all needs and risks identified in the assessment. While most are at least adequate, too few are good. Plans that are not good are often too long and do not incorporate specific and measurable outcomes. They do not separate out the key areas of risk and there is no contingency recorded. Reviews are not always used as effectively as they could be to drive forward the progress of the plan, meaning that, in a minority of cases, issues are allowed to drift and there is insufficient challenge to ensure adequate progress is being made.

25. There is a variable response to children who go missing and those who are at risk of child sexual exploitation. Children missing from home who are not known receive a return home interview from the missing person liaison officer. Young people open to children's social care, including young people who are perceived to be at high risk, usually receive a return home interview. Where these do take place, records of these interviews indicate that young people are seen alone, and a detailed record provides an account of what caused the missing episode. However, interviews are not routinely collated to build up a picture of the individual young person's behaviour. Nor are they collated to look at overall themes in order to feed into future service-planning.

26. A weekly multi-agency case tracking meeting is held to maintain an operational overview of the young people considered most at risk from child sexual exploitation. However, the meetings do not always track the absence of return home interviews and notes from the case-tracking meeting are not consistently transferred onto case records. It is not, therefore, easy to see what impact these meetings are having on the day-to-day management of risk in these cases, particularly as police as key partners do not always attend. The child sexual exploitation risk assessment checklist, although developed, is not routinely used. The recent creation of the post of specialist senior sexual exploitation social worker has had some impact in terms of identifying risk and raising awareness of these issues. However, it is early days and responses to the risk of child sexual exploitation remain inconsistent.

27. The reasons why children miss education are well understood. The local authority maintains an up-to-date list of all those missing education and a lead officer for children missing education and a monitoring board are in place. Monitoring meetings focus on those cases causing most concern and a high proportion of interventions result in children returning to school. The attendance and welfare service has been proactive in visiting 74 families whose children had not taken up a secondary school place at the end of Year 6. As a result, 67 of these children started school in September 2015.

28. The local authority has a good focus on children whose parents choose to educate them at home, with a sound knowledge of the cohort. The reasons for choosing elective home education are well understood. Staff are persistent in ascertaining the suitability and effectiveness of the education that children receive and have a strong focus on children's welfare needs. In cases where there are significant causes for concern, effective action is taken to promote school attendance and children's welfare.

29. When 16–17-year-old young people present as homeless, an initial child in need assessment is undertaken by housing, and mediation is offered. The implications of becoming looked after are explored with young people. A dedicated social worker assesses the young person's situation and provides appropriate support.

30. Private fostering arrangements are identified well within the borough. Some active awareness-raising has led to an increase in notifications. Recent assessments seen were of a good quality. Inspectors reviewing these cases found, on a number of occasions, children who had no adult who held parental responsibility for them. This had been identified within assessments, but not robustly addressed. During the period of the inspection, the local authority formed an appropriate proposal to strengthen its response to such cases.

31. The designated officer, who is suitably qualified and experienced, effectively manages, in a timely manner, allegations against people in a position of trust. Effective management systems track the progress of all cases from the point of initial consultation, ensuring that actions are promptly completed. The number of allegations is rising, particularly referrals from schools. The role is highly valued by headteachers, who appreciate the support and guidance given.

The experiences and progress of children looked after and achieving permanence	**Good**

Summary

Effective edge-of-care support means that children are looked after only when necessary, after all other alternatives have been fully explored. If their plan is to return home, they do so with appropriate support in place. A permanent home is secured for those children who need it as quickly as possible and they are provided with placements that appropriately reflect their needs, with adults who help and promote their health, education, culture, ethnicity and identity.

Social workers know the children they work with well and visit them regularly to ensure their safety, progress their plans, and promote their well-being, leading to improved outcomes. Children and young people's views are reflected in their plans and they are listened to. When children go missing, the risk is assessed and measures put in place to keep them safe.

Child and adolescent mental health services (CAMHS) provide outreach support in schools, foster placements and residential homes, including for those children who live outside the borough, but some children wait too long to receive a service. Needs are assessed and most children access services that promote and improve their health outcomes. However, not all children have their need for substance misuse services identified.

The virtual school provides robust oversight of attendance, progress and attainment, and many children looked after make good progress from their starting points. There are few absences from school and no children are permanently excluded or missing education. Monitoring of the progress of children looked after continues post-16, which helps them to secure appropriate education, employment or training (EET).

The LA maintains contact with almost all of its care leavers. Workers know the young

people well and maintain regular contact with them. They offer good support to young people based on their individual needs and circumstances. Good support is available through the weekly multi-agency drop-in, resulting in a high proportion of young people in EET. Young people are supported well to think about and explore university as an option and almost all young people live in suitable accommodation.

Adoption performance is a strength. Children and potential adopters are carefully assessed and permanent homes are found that meet the needs of children. Post-adoption support is effectively provided to children, adopters and birth parents. The adoption panel reaches robust decisions for children. The panel chair's six-monthly reports currently lack sufficient detail to support learning.

Inspection findings

32. Effective family support services for those children and young people on the edge of care ensure that children remain within their birth family wherever possible. As a result, numbers of children looked after have remained stable over the last three years. Senior managers ensure that there is appropriate and robust application of care thresholds and that all safe alternatives to care are considered. At the time of the inspection, there were 467 children and young people looked after. Children who return home to live with parents or other family members do so with an appropriate plan of support.

33. A comprehensive and structured legal planning process guides social workers to consider family members at the earliest opportunity when the local authority's plan is for permanency, other than with birth parents. Recording shows timely consideration of permanence plans. All occur before the second child looked after review, with appropriate discussions, challenge and contingency parallel planning. Effective letters before proceedings reinforce the opportunity for parents to consider wider family members to care for the child. Letters to families' legal representatives demonstrate a comprehensive consideration of alternatives to care. Appropriately experienced and well-supported social workers ensure compliance with the public law outline (PLO). Thorough pre-proceedings preparation ensures that carefully considered cases are presented in court.

34. Close monitoring of individual cases by local authority lawyers ensures compliance with care proceedings timescales in most cases. The average length of care proceedings is 32 weeks, due to a small number of complex cases. More recent cases were heard within the expected 26-week timescale. Reports for court consider the range of options for securing permanence for children, giving weight to the most appropriate option for the child. The quality of court statements is consistently good, minimising the need for further expert assessments. Comprehensive viability assessments of family members avoid unnecessary delay. Parenting assessments commissioned by a specialist family centre produce high-quality reports, although the timeliness of a minority cause some delay in proceedings. The Children and Family Court

Advisory and Support Service (Cafcass) and the local judiciary both report positively about the quality of plans and performance of the local authority.

35. Children are visited regularly, including those placed out of the borough, within timescales that are compliant with statutory requirements. Established and positive relationships with their social workers help children and young people to make progress. In almost all cases, there is good continuity of social work support. Social workers and carers effectively help children to prepare for permanence and ensure that they have a good understanding of where they will be living and who their carers will be. Case records evidence tenacious work that engages young people in their plans and reviews.

36. A specific anti-bullying strategy for children looked after provides effective guidance to schools, children's homes and foster carers on identifying and responding to incidents of bullying. Incidents in school are rare due to proactive monitoring of progress of all children looked after. The fostering service successfully delivered seven well-attended workshops to foster carers during 2014–15. This training appropriately explored celebrating diversity and also helped foster carers to consider the effects of discrimination, prejudice and stereotyping on children.

37. Identification of risk associated with children going missing is evident in assessments, and plans are in place to reduce risk. Return interviews are taking place but inconsistent recording does not provide an overview of risk, in most cases seen. A lack of analysis at strategic level misses an opportunity to understand patterns and therefore disrupt such exploitative activity.

38. Performance on initial and review health assessments (RHAs), development checks for children under five, immunisations and attendance at dental appointments has declined in the 12 months to March 2015, but remains higher than statistical neighbours and the England average. In 2014–15, RHAs dropped to 91.4%, under five development checks to 97%, and immunisations to 88.8%. The service is addressing this and monitors performance at a quarterly contract meeting, providing oversight of improving progress. Additional dedicated nurse time and administrative support have recently been provided to reduce a backlog of health assessments, of which there are approximately 30 at the end of October 2015.

39. 'SYMBOL' is the CAMHS service for children looked after. It consists of a team of social workers, family therapists, a clinical psychologist, drama therapist and consultant psychiatrist who work well together to meet need. Effective working with the virtual school provides outreach support, consultation to foster carers and training and consultation to professionals to improve outcomes. Lack of capacity, due to a job vacancy, has resulted in children with identified mental health needs waiting over two months to access services, therefore not receiving help when they specifically need it. Numbers of children looked after identified with a substance misuse problem are low. In 2013–14, this was 4% (15 children); however, all these children received an appropriate intervention.

40. The virtual school team provides good oversight of the attendance, progress and attainment of children looked after. Through close monitoring, the virtual school team identifies quickly when the attendance of children begins to decline and they start to experience problems at school. This enables staff to put in place timely additional support that helps children to remain in school, maintain their attendance and make progress. The majority of children are placed in a good school and attendance at school is very good. Local data show that in 2014–15 the average attendance of children looked after was 93% attendance, and in-year data show that during this academic year attendance has improved further to 95.5%.

41. Many children looked after make good progress from their starting points. Data show that 60% of children looked after in the borough made the progress expected of all children in 2013, compared to just 36% of children looked after nationally. In the last academic year local data show that over half of children looked after did so. Considering the high proportion of these children with special educational needs, this demonstrates good performance.

42. The virtual school works effectively with its partners to help children stay in school and keep them on track in their learning. As a result, fewer children looked after are receiving fixed-term exclusions from school. In the last academic year, 39 children were subject to a fixed-term exclusion, compared with 49 in 2013–14. No children looked after have received a permanent exclusion in the last two years, whereas the number of pupils being permanently excluded from secondary schools has risen. Children who do not attend a mainstream school are placed in registered alternative provision and a 25-hour a week timetable is in place. Only three children who have recently arrived in this country are missing education while awaiting a school place. They are actively engaged with individual learning packages that the virtual school team has promptly put in place.

43. The virtual school effectively supports children and young people at key points of transition. In September 2015, all those transferring to secondary school began Year 7 at their first-choice school. The good monitoring of children under 16 years old continues post-16. Young people are encouraged to consider their next steps in learning through additional activities such as visits to careers fairs. These activities help young people to broaden their horizons and consider carefully their career options. All young people who completed Year 11 in 2015 had in place an education or training offer. The small number who are currently not in education, employment or training (NEET) receive very good support to help them engage. Staff from the virtual school have excellent knowledge of each young person and are very proactive in supporting them towards education, training and employment.

44. For the small number of children looked after for whom published data are available, their attainment shows a mixed picture. At the end of Key Stage 1, children's attainment in reading, writing and mathematics was below comparators in 2013/14. At Key Stage 2 in 2013–14, children's attainment

improved in reading and mathematics. Local data for the last academic year show that, at Key Stage 4, 19% of children looked after achieved five GCSEs, including English and mathematics. This was a good improvement when compared with the 12% who did so in the previous year. While the attainment gap between children looked after and their peers remains wide, in 2013/14 at Key Stage 2, the gap closed significantly on all measures.

45. The virtual school has rightly identified that the quality of personal education plans (PEPs) varies too much. Academic targets are not always prominent enough or clear and the views of children are not always sufficiently recorded. In response, the virtual school is providing training for social workers, foster carers and designated teachers to improve the quality of PEPs. Children and young people spoken to by inspectors reported that PEP reviews were a good opportunity to check that they were on track in their learning.

46. The pupil premium is used well by the virtual school to support effective borough-wide initiatives such as study support and Fast-Track, a programme that targets 16- and 17-year-olds without an education place. At the weekly, well-attended study group, children looked after receive additional help in a relaxed and purposeful environment. They enjoy attending and told inspectors how much they value this additional support that helps sustain their progress well. The use of the pupil premium is closely aligned to the educational goals of children looked after, and additional one-to-one support they receive is effective.

47. Local authority staff effectively promote opportunities for children and young people to pursue their interests. Children looked after have free access to local leisure facilities. Staff, children and young people are supported by the council to pursue fundraising activities that enable children looked after and care leavers to participate in exciting overseas educational trips and holidays. These trips provide them with excellent opportunities to develop their personal and social skills, develop their sense of responsibility, broaden their horizons and inspire them to achieve well.

48. Care plans seen by inspectors are of a good quality. They appropriately identify all areas of need and risk. In cases seen, recent reviews mostly take place within timescales (98.3% in 2014–15). Appropriate challenge is evident by the independent reviewing officers (IROs) to progress care plans. In one example, reduced risk was evidenced by a detailed assessment, which included clear actions in relation to a young person who had been missing from their placement. Another case evidenced an appropriate response to disclosure of sexual abuse, with the assessment reflecting concern and clear management oversight guiding actions.

49. The low number of formal safeguarding alerts by IROs (25 in the last 12 months) reflects good practice as most issues are progressed through informal routes. Comprehensive monitoring by IROs captures themes and issues for practice improvement considered by senior managers. For example, this has

led to changes to promote the better quality and consistency of the interpreting service for unaccompanied asylum young people (UAYP) as well as a clearly articulated 'staying put policy' for foster carers.

50. The needs of children are carefully matched with skilled foster carers. Thorough assessments of children, their needs, wishes and views are apparent when considering appropriate matches. Placement workers within the fostering service work efficiently to identify placements in a timescale to meet children's needs, including identifying appropriate cultural and religious matches. Emergency placements are effectively identified where these are required. A dedicated team in the fostering service provides good support to kinship carers.

51. Once matches are agreed, children are prepared well for moving into their new homes. This includes ensuring that they are able to maintain meaningful contact with parents and family members when this is in their best interests. Life story activity undertaken by foster carers helps children to understand their past; however, it does not consistently lead to children having a completed life story book in later life. Contact arrangements, facilitated by a commissioned service, enable brothers and sisters to meet up with each other in community venues.

52. The local authority effectively ensures that they have a range of placements available to meet the needs of children through targeted recruitment and support to their in-house foster carers. An independent agency delivering the recruitment and assessment functions over the past three years has effectively increased the pool of in-house carers for mainstream placements. In 2014–15, 30 newly recruited fostering households led to a net gain of 17.

53. At the end of October 2015, there were 148 fostering households and a further 14 family and friends caring households. There is a vacancy rate of 31% (47), with over half of these (24) being held as 'vacant' for planned reasons such as a young person remaining in placement under 'staying put' arrangements or to enable brothers and sisters to be looked after in the same placement.

54. The local authority has appropriately identified that it now has sufficient numbers of mainstream carers and is exploring options to increase the number of households able to provide good-quality homes for teenagers, brothers and sisters together, children with complex needs and mother and baby placements. Consequently, it has set a lower target to recruit 20 new fostering households for 2015–16, with the aim of attracting carers with the skills to take these more specialist placements. More recently, the local authority has joined a London-wide group as part of a larger preferred providers list to increase its range of placement options.

55. Reports to the fostering panel for approval of foster carers are sufficient to inform appropriate decisions and have improved in quality over recent months. The assessments of potential foster carers are of a good quality, providing a

thorough overview of essential information, together with detailed analysis and appropriate recommendations.

56. Foster carers spoken to by inspectors said that they appreciated the support they receive from supervising social workers. Regular supervision enables them to reflect on the care that they are providing, and identifies specific training needs. Experienced foster carers mentor newly approved applicants to provide additional support when children first come to live with them. At October 2015, the annual appraisals of foster carers that supervising social workers are required to complete were not all sufficiently timely to meet the regulations, with 18 of 155 delayed.

57. Two groups of the Children in Care Council, a younger group for children up to 13 years old, and an older group for those over 13 years old, meet once a term. This is facilitated by a participation worker who is held in fond regard by the children and young people. Children and young people access social opportunities to discuss their experiences, interact confidently with adults, and make positive contributions to developing services for children and young people looked after. Young people receive training to help them to be involved in staff appointments, including the recent appointment of the Director of Children and Young People's Services. They spoke positively about celebrating their achievements at an annual event, organised by themselves and attended by the Mayor and members of the corporate parenting panel.

The graded judgement for adoption performance is that it is good

58. The local authority effectively considers permanence, including adoption, for all children looked after under 10 years old, prior to their second review. During 2014–15, 36 children were placed for adoption and there has been a positive year-on-year increase over the past few years (24 children were placed in 2012–13 and 27 placed in 2013–14). This performance has, however, dropped a little in the first two quarters of 2015–16, with only 10 children being placed.

59. The local authority is persistent when securing adoption for children with more complex needs, with the majority being placed within 14 months of agreeing their plan for adoption. Children successfully placed over the past year have included a brother and sister placed together who have a challenging family history, children with complex health issues, and a child with uncertain health outcomes due to parental mental and physical health issues.

60. The local authority's performance against the adoption scorecard is strong. Its performance for 2011 to 2014, the most recently published scorecard data, shows the time between children entering care and moving in with their adoptive families was 547 days. This was lower than the England average of 628 days and lower than statistical neighbours at 741. From 2012 to 2015, they improved their performance and reduced this timeframe to an average of

513 days, with data for the first two quarters of 2015–16 showing further improvement.

61. The percentage of Lewisham children who wait less than 18 months between entering care and moving in with their adoptive family was 48% for the period between 2011 and 2014, which is below the England level of 51% and above statistical neighbours at 44%. The local authority data show improved performance in 2012 to 2015, with 67% of children waiting less than 18 months to move in with their adoptive family from entering care.

62. The average number of days between receiving court authority to place a child to be adopted and the local authority deciding on a match with an adoptive family was 170 days during 2011 to 2014. This is lower than the national average of 217 days and statistical neighbours at 253 days. Between 2012 and 2015, the LA's data again show improved performance against this measure, to an average of 158 days between court order and identifying a match for the child. The LA projects a slight drop in performance during the first two quarters of 2015–16; they understand the reasons for this and are working appropriately with three children who waited longer than average before being matched with their adoptive placement.

63. Assessments for children and their families recorded within child placement reports (CPRs) are thorough, with all information being carefully considered and analysed by the children's social worker. This includes careful consideration of family history, culture, ethnicity and religion, as well children's developmental needs. These detailed assessments support robust matching processes and feed into high-quality adoption placement reports (APRs).

64. The adoption service successfully uses a range of options for attracting and recruiting potential adopters, including local papers and the local authority website, the South London Consortium and targeted work with religious groups. The local authority plans to recruit 27 new potential adoptive families in 2015–16 and is on target to achieve this. The local authority appropriately identifies that its priorities are to recruit: adopters for children of all ages of African and African Caribbean ethnicities, and children of dual heritage; sibling groups where the youngest child is over three years old; children over five years old; and children with disabilities.

65. The local authority is diligent in exploring the possibility of dual registration, as concurrent carers or foster to adopt, with all potential adopters during their assessment and preparation phase. The vast majority decline to take this option because of the risks involved of losing a child from their care, but two couples have chosen to become concurrent carers.

66. The adoption team is persistent in identifying suitable and stable matches for children with adopters and uses all resources available to secure these. This includes considering in-house adopters, advertising with the London Consortium and adoption register, and also undertaking exchange and activity

days. At the time of the inspection, the local authority was actively working with 32 children who have an agency decision for adoption. Of these children, 24 have a placement order; of these, 12 children are matched and placed with adopters and four children are living with foster carers who are currently being assessed as prospective adopters for them. The local authority is finding families for the remaining eight children.

67. A skilled and experienced independent chair provides appropriate guidance and challenge to panel members. Strong reports from social workers and robust processes enable the panel to reach appropriate recommendations regarding the approval of potential adopters and to make secure recommendations regarding placement of children. The six-monthly report from the adoption panel to the local authority is brief and lacks sufficient information to support effective learning. There are some delays in the timeliness of agency decision-makers' decisions due to competing workload demands. Very recently, the new Director of Children's Social Care has appropriately agreed a new process to streamline the timescale for the agency decision-maker, following panel meetings.

68. Careful planning for introductions ensures that children move into their new home at a pace that meets their needs. There is flexibility within adoption services to ensure that the number of placement moves is minimised for children, for example with panel and placement dates being brought forward to prevent the need for respite placements. Adopters speak highly of the preparation and support they receive prior to children being placed with them.

69. Effective support is provided to children and their potential adopters after placements start, and continues to be available prior to adoption orders being granted. For example, social workers have worked effectively with schools to provide advice regarding attachment issues and appropriate behaviour management for children in potential adoptive placements. Additionally, where required to support placements, very regular support visits are undertaken with children and their potential adopters to seek to resolve emerging issues. This often includes undertaking some therapeutic play sessions to help children settle effectively into their new homes. All social workers in the adoption service have been trained in this approach. The flexible offer of support and robust matching of children with potential adopters leads to secure adoptive placements for Lewisham children. There have been no disrupted placements for over two years.

70. A comprehensive post-adoption support offer is available to adopted children, adopters and birth families. There is a generic offer of support to all, and additional assessments are undertaken when additional needs are identified by social workers or referred by families. The adoption support team operates a duty system to ensure that all urgent referrals are allocated on the same day and visits with families are undertaken quickly to identify and deliver appropriate support. During 2014–15, the adoption support team received 94 new referrals: 17 from adoptive families, 22 from birth families and 56 from

adopted adults. There is also a range of training sessions available, which are well-attended and highly valued by adopters. Workshops include subjects such as education, attachment and health; there is evidence of the local authority effectively acting upon feedback from adopters in delivering new workshops, for example developmental trauma and social media.

71. The adoption support service also provides therapeutic and financial support to families who have a special guardianship order. In 2014–15, the training programme included workshops specifically targeted for special guardians and included sessions such as contact, life story work and grief and loss.

72. An element of good adoption support is the joint work being undertaken with CAMHS colleagues for the assessment and support of families in urgent need of therapeutic intervention. In the past year, 12 families have received support via this joint work, with a further four being referred to the adoption support team to continue support when the CAMHS input came to an end. It is of note that most families using this service are non-Lewisham adopters with children placed by other local authorities more than three years ago, who now live in Lewisham.

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

73. Social workers and personal advisers maintain contact with nearly all of their care leavers. The latest available data shows that there are just two care leavers they are not in touch with. Personal advisers know young people well and maintain regular contact with them via text, email and visits, including with young people who live outside of the area.

74. Personal advisers, social workers and key workers offer good support to young people based on their individual needs and circumstances. For example, personal advisers liaise well with care leaving services outside Lewisham and broker practical help for young people to assist them with housing and employment.

75. In cases sampled by inspectors, all young people had an up-to-date pathway plan and these were mostly of good quality. The routine assessment of young people's needs prior to their 18th birthday means that pathway plans are based on a recent social work assessment of need. Assessments customarily address the key areas in young people's lives, including the risks facing them and the measures needed to ensure their successful transition to independence. Inspectors saw good examples of re-assessments where young people's needs and circumstances had changed, such as a change of personal adviser or a breakdown of their college placement.

76. Personal advisers routinely update pathway plans to reflect young people's changing circumstances. Advisers involve young people well in planning and

plans are based on the practical tasks necessary to help young people achieve independence. Plans are generally of a high quality and the best plans set out clear actions to respond to young people's sometimes complex and changing needs. A small minority of assessments did not identify well enough how young people's needs would be met.

77. Specialist staff for education, employment and training, benefits and entitlements and substance misuse provide good support to care leavers at a weekly drop-in session. A good proportion of young people are in education, employment and training (EET). In 2013–14, 61% of 19–21 year olds were in EET, compared to just 45% nationally.

78. Young people at university benefit from support from the specialist careers advisers. The virtual school and a specialist careers adviser effectively promote higher education as an option through, for example, open days at universities. As a result, an increasing number of young people attend higher education. There are currently 38 care leavers at university. They receive a good package of financial support, including the costs of accommodation during holiday periods.

79. The vast majority of care leavers live in suitable accommodation. In 2014–15, 96.7% of care leavers did so. There is a good range of accommodation available to care leavers, including semi-independent and independent accommodation and an increasing number of supported lodgings. A greater number of care leavers are being effectively supported to remain with their foster carers when they reach 18 years of age. In November 2014, just 11 young people were living with their foster carers under staying put arrangements. By November 2015, the number has increased to 36.

80. Young people are only placed in houses of multiple occupancy (HMO) when it best meets their needs. Inspectors visited two houses of multiple occupancy and found that the accommodation was safe and of very good quality. Young people in HMO receive support from visiting or on-site key workers. At one house, the cultural needs of unaccompanied asylum-seekers are met well by placing young people with similar experiences and backgrounds together. Key workers and the virtual school effectively support young people to settle quickly, become independent and engage in education. Staff understand young people's individual needs well and liaise effectively with other agencies to ensure that young people's educational and cultural and welfare needs are met. Bed and breakfast accommodation is only ever used in an emergency and when all other immediate options have been exhausted.

81. The nurse, social workers and personal advisers for children looked after promote young people's health and well-being effectively. All young people are offered an annual health review by the children looked after nurse prior to leaving care and receive a discharge letter with their full health history. This helps care leavers access relevant health services and enables young people to

use this information to better manage their own health and seek specialist advice where necessary.

82. Care leavers spoken to by inspectors were aware of their entitlements. Financial support provided by the local authority supports young people's aspirations and transition to independence well. Care leavers receive a range of entitlements, including a grant to equip their first home, access to a discretionary learner support fund for those in further education and assistance with travel costs and stationary. Those at university receive an annual allowance that supplements their student loan.

Leadership, management and governance	**Requires improvement**

Summary

Leadership, management and governance require improvement to be good. Progress has not been sustained in all areas since Ofsted judged the local authority as outstanding for safeguarding and good for children looked after in 2012. Elected members, the chief executive and senior managers have not rigorously scrutinised data or performance information to ensure that they have an accurate understanding of the quality of practice in all areas of the service. This deficit is compounded by delays in addressing long-standing issues with data reliability. Staff do not systematically record all activity on the local authority's children's electronic case system.

The local authority recognises the need for further work to achieve better performance and quality assurance information, and consequently greater consistency in management oversight. Performance information is not reliable and therefore cannot be used to enable effective scrutiny of performance. Audit activity, although occurring, is not used effectively to improve practice.

The new management team demonstrates a clear understanding of the challenges ahead for the local authority. The focus has, by necessity, led to a review of service responsiveness, including thresholds, the quality and timeliness of child protection processes and the need to replace the electronic case recording system. Services for children looked after remain good and have improved for care leavers.

The quality of early help work is significantly under-developed. There is no coordinated overview of early help provision across Lewisham, and senior managers do not evaluate impact. Arrangements for children who need help and protection require improvement as services are variable and not all are good. Children looked after live in homes where their needs are met well. Adoption is given appropriate consideration for all children needing permanence. Assessments of adopters are robust and timely. The authority has high aspirations for its care leavers and supports them well.

Retention of a strong and motivated workforce is a key priority for the borough and senior leaders give priority to recruiting and retaining skilled staff. The workforce strategy and training plan are appropriately aligned. Training and support is effective in promoting high morale within the workforce. The local authority has invested to ensure that social workers have manageable caseloads that support this achievement.

When children and young people go missing from home, care or education or are at risk of sexual exploitation, the local authority and other agencies in Lewisham work hard individually to prevent them from coming to harm. However, effective multi-agency arrangements are not yet fully in place to ensure that these vulnerable children are fully safeguarded.

Inspection findings

83. Leadership, governance and management arrangements comply with statutory guidance. There are regular meetings between the Mayor, key officers, members and the independent chair of the Local Safeguarding Children Board (LSCB). However, elected members and the chief executive are not always effective in holding senior managers and officers to account in order to assure themselves that children's needs are identified and met. There has been a delay in recognising some service shortfalls. The formal arrangements to discharge the local authority's children's scrutiny function for help and protection do not provide sufficient focus or challenge on aspects of the service that require improvement.

84. A new Executive Director of Children's services was appointed in September 2015. She has very quickly recognised flaws in social work systems and processes that compromise conditions for good social work practice. Building on these findings and those of the interim Director of Social Care, she commissioned a thorough self-assessment of children's services and alerted senior leaders to areas of concern so that they could take action to address these. With the active support of the recently appointed Lead Member, an action plan has been produced to take this work forward.

85. The new leadership has already made progress in developing an open and positively challenging culture. The local authority now knows its service deficits and plans are in place to prioritise addressing these. In some instances, such as compliance with *Working Together* guidance regarding the timeliness of strategy discussions, practice deficits have already been addressed. The need to include health and other partners more routinely in strategy discussions and planning remains work in progress.

86. A service priority is the replacement of the information technology platform on which the electronic records system sits as this remains a stubborn obstacle to good practice and planning. Significant investment has been agreed to ensure

improvements to information technology. This will support social workers to be more effective and efficient in their work.

87. The workforce itself is a considerable strength of the service within Lewisham. Workers and managers improve outcomes for children and young people despite deficiencies in performance management arrangements and the absence of robust pathways for practice. Almost without exception, they were found to be committed and enthusiastic in delivering child-centred practice to improve outcomes for children and young people.

88. The local authority partnerships with other statutory and voluntary agencies are strong and well established. There are effective working relationships with partners on strategic boards, including the Local Safeguarding Children Board, the Children and Young People's Strategic Partnership Board and the Health and Wellbeing Board. Children's needs are duly considered and priorities across boards are appropriate and well aligned. The key priorities are set out within the Children's and Young People's Plan developed in collaboration with key partner agencies and the voluntary and community sector. Children and young people are consulted through youth-led commissioning groups, including those involved in the Headstart project.

89. A Joint Strategic Needs Assessment is in place that informs strategic planning for children's services. It does not, however, give clarity in relation to sufficiency of placements for children looked after to ensure that recruitment and planning achieves an appropriate balance of local and in-house provision to match need. The local authority is not sufficiently specific about the identified groups of young people for whom placements may be required, and has only recently set out what it plans to do to secure sufficient placements for them.

90. The local authority has some systems in place to manage and monitor performance in children's social care, but this has been impeded by significant difficulties in extracting accurate data from the children's electronic recording system, described by its own officers as 'antiquated'. Performance monitoring lacks rigour as reports are drawn from an electronic system that is recognised within the authority as unreliable. The data presented is of limited value as it cannot be fully trusted. It is of concern that a number of social workers and managers have such a lack of trust with the system that they maintain their own records. At various points throughout the inspection, the local authority struggled to provide accurate data for some service areas.

91. In addition to the problems with quantitative data, qualitative information is not being used well to support service development and drive improvement. Not all services are being evaluated through audit. This means the local authority does not yet have a full understanding of the impact all services have on children. The audits undertaken by the local authority for this inspection were variable in quality, with too great a focus on process rather than outcomes. Nevertheless, in most cases there was congruence in the findings of

the local authority and the inspection team. This provides evidence that the local authority recognises the fundamentals of good practice that need to be standardised practice across the service.

92. The local authority has invested resources to ensure that caseloads are manageable and that all work is allocated. Staffing levels have been maintained, although there is a reliance on recently qualified social workers, particularly in family social work teams. For these social workers, there is a clear professional development framework in place. All newly qualified social workers during their assessed and supported year in employment undertake a comprehensive induction and a range of mandatory training and benefit from protected caseloads. Newly qualified workers reported to inspectors that they feel well supported in their teams.

93. The training plan links well to the workforce strategy. The revised workforce development strategy demands better standards of practice and robust management of staff performance. An effective range of opportunities are in place to develop social workers' skills and knowledge. Social workers reported that training is readily available and of good quality. A career pathway for social workers has been developed within a good workforce planning strategy, informed well by an annual report and analysis of recruitment and retention issues.

94. Supervision of social workers and managers does not consistently take place in accordance with the local authority's policy. Managers and leaders are visible and accessible to staff, who report them to be appropriately knowledgeable. However, inspectors still found some staff and managers failing to promote basic social work standards. For example, there was not always evidence of sufficient challenge of poor case recording or to ensure the updating and meaningful use of chronologies. Similarly a number of plans are of poor quality. Too frequently these were 'signed off' by managers, suggesting such practice is acceptable.

95. Partnership arrangements are generally effective and enhance the drive to improve services and outcomes for children and young people. For example, good systems and arrangements are in place to track and check the safety and achievements of home educated children and children missing education. Partnership working has led to a higher than average proportion of care leavers moving into education, employment and training than that found nationally.

96. Joint commissioning is a strength of the organisation. Sound commissioning processes are delivered by a dedicated and experienced team of joint commissioners in line with the commissioning cycle. Examples were seen of strong needs analysis, development of specifications, procurement practice and of evaluation, with an emphasis on collaborative commissioning methods. Commissioning was at its strongest where joint commissioners held responsibility for delivering the full commissioning process in partnership with

existing providers, for example the development of an extended CAMHS under the national Future in Mind initiative.

97. Arrangements are less robust where the joint commissioner is responsible for only part of the commissioning process, such as early intervention or looked after children placements. In such instances, the partial and untargeted use of joint commissioning expertise meant that the involvement of a joint commissioner did not add sufficient value to the commissioning process as a whole.

98. Strategic oversight of child sexual exploitation is disconnected and underdeveloped. Information collated by the local authority on the number of children who are at risk of child sexual exploitation or of going missing from their family homes or care is limited. It is not used to inform planning to keep individual children and young people safe, nor is it collated and analysed to identify key themes that could ensure there is strategic planning to tackle these problems. Work in this area by children's services, the police and other partner agencies are not well coordinated. Although there is an over-arching strategy regarding child sexual exploitation, it is ineffective.

99. Lewisham is an active and committed participant in the work of the local Family Justice Board. Relationships with Cafcass and the judiciary are strong and, as a result, timescales within court proceedings consistently meet or exceed expected targets.

100. The member-led corporate parenting panel takes a clear interest in the progress of looked after children and care leavers and celebrates their successes. Structures for the delivery of corporate parenting are in place and established, with evidence of positive impact. However, the recently appointed Chair of the Corporate Parenting Group acknowledges that more work is required to facilitate the greater engagement of young people and sharpen the scrutiny function in so doing. The children in care group has engaged in addressing some issues of concern. One example of its influence was ensuring that staff working within the care leaving service retained council phones to aid communication when staff in other teams were having these withdrawn as a savings measure.

101. The local authority receives feedback from a range of young people's groups, which, in some instances, has resulted in positive changes in practice. These have included contributing to senior management appointments and the development of the younger children in care group. The children in care council has had some impact in helping to improve services for children looked after and care leavers.

102. Most of the key recommendations from the safeguarding and looked after children's inspection (SLAC) 2012 have been met. However, the requirement that child in need plans contain measurable actions and outcomes is yet to be achieved.

103. Complaints are managed well by a designated complaints manager. Learning from complaints is appropriately cascaded to managers. The local authority appropriately made three serious incident notifications to Ofsted since the previous inspection in 2012.

104. Lewisham is a Home Office Prevent Area, tier one. The Prevent team has been in place since 2012. There is evidence of strong partnerships, including a multi-agency Prevent board and effective links with schools and colleges. These and comprehensive training arrangements across the borough have resulted in raised awareness among agencies and community groups, who share information and intelligence to identify and help prevent young people who are at risk of becoming radicalised. As a result, there has been an increase in referrals to the Prevent team and to Channel meetings, and interventions made to divert young people from radicalisation.

The Local Safeguarding Children Board

The Local Safeguarding Children Board requires improvement

Executive summary

The Local Safeguarding Children Board requires improvement to be good. Local authority children's service partners have lacked the capacity that would allow the board to put an early help strategy in place in line with its business plan. This omission, aligned to the absence of an up-to-date threshold document, contributes to an overall lack of direction for early help services. The lack of a clearly identified governance role for the board's child sexual exploitation (CSE) sub-group is contributing to deficit in the multi-agency response.

Performance reporting is a particular weakness. Corrective measures have recently been put in place to address this deficit, but a current lack of accurate reporting has led directly to circumstances in which the board was unaware of several of the areas of weakness in multi-agency practice identified by this inspection.

An effective forward plan ensures that the board regularly receives the reports it requires in a timely manner. Key documentation such as the annual report and the business plan is in place but is not generally well-aligned, and there is no clearly identifiable set of strategic priorities threaded throughout the board's records. Board meetings are not well recorded, and a high number of action plans means that it is not always possible to link the board's records with its overall priorities.

Robust protocols ensure that the board is well connected with other governance bodies and that its independence is assured. Partners demonstrate a strong commitment to the board, and they have recently agreed an increase in funding. Board meetings are well-attended and a significant strength is a culture of challenge, which is appropriately logged and monitored.

Implementation of the learning and improvement framework shows signs of considerable improvement following development activity undertaken last year. Four thematic audits are programmed annually as a satisfactory auditing programme and considerable effort has been expended to ensure that schools are enabled to participate in the agency audit under section 11 of the Children's Act 2004.

A satisfactory training strategy results in the delivery of a limited training calendar delivered by approved trainers, and an extended evaluation process has recently been introduced to ensure its effectiveness. The board is currently working with young people's groups to design a more user-friendly website. This will include localising the board's policies and procedures and improving professionals' recognition of board activities.

Recommendations

Priority and immediate action

105. Review the board's early help and threshold documentation in the light of changes to frontline services as part of an overall review of the early help offer within the local authority area.

106. Clarify the governance role of the board's sexual exploitation sub-group to align it with other groups within the local authority area.

107. Implement fully the performance framework to ensure that there is interrogation of performance reports to provide a clear understanding of any exceptions or deficits.

108. Streamline action planning and ensure that any actions undertaken are aligned with the board's priorities.

Inspection findings – the Local Safeguarding Children Board

109. Lewisham Local Children Safeguarding Board (LSCB) meets its statutory duties and undertakes a broad range of work to safeguard children in the local area. Partners demonstrate a high level of commitment to the activities of the board. For instance, they are providing further investment to the board at a time of significantly reducing resources. This has allowed the board to employ a development officer who augments the dedicated and talented board team in delivering a wide-ranging business support plan. However, board members accept that there is much more to do to assure themselves that frontline services are being delivered in an effective way.

110. A proactive independent chair, who is also the chair of the Adult Safeguarding Board (ASB), leads the board. She has the trust and support of the multi-agency partnership. They describe her as 'rigorous and systematic' in aligning the activities of the LSCB with the ASB, and in ensuring that actions are satisfactorily completed. Well-attended board meetings are not well recorded and, although actions are followed up from meeting to meeting to ensure that they are completed, it is not always possible to determine how they relate to the board's overall priorities for improvement.

111. The board has completed a comprehensive annual report and put in place a business plan; however, these documents, and board documentation generally, are not well aligned. The board operates appropriately to a forward plan to ensure that it receives required reports, such as on private fostering or elective home education. This high level of activity has resulted in a large number of action plans. Where actions are clear, they are rigorously followed up, but are not well-connected. More needs to be done to ensure that an energetic board has a set of clearly understood strategic priorities threaded throughout all of its activities.

112. Robust protocols are in place to ensure that the board is well linked to other partnership forums, such the Children's Partnership and Health and Wellbeing Boards. Clear accountabilities are in evidence between the board's independent chair and the council's Chief Executive.

113. The board operates an appropriate culture of challenge. Formal challenges are logged and their outcomes monitored. One significant recent example of this came with the challenge by police partners to the operation of the MASH. Specifically, this challenged the manner in which recording a series of contacts dealt with by different referral and assessment team managers did not consistently result in the build-up of intelligence in cases. This may be critical in cases involving, for example, sexual exploitation or neglect, which are often not identifiable through a single incident. As a result, the board has agreed to an independent review of the duty service, but this had not begun before this inspection made the same finding.

114. The Child Death Overview Panel's (CDOP) is well chaired and carries out its functions effectively. CDOP reports regularly to the board and produces a well-written annual report on themes and trends in child death. The chair of CDOP is also responsible for the rapid response to children's deaths and ensures that they are understood well.

115. The board has recently reviewed and improved its practice on the conduct of SCRs. The report format and action planning have been refined, and a monitoring system introduced that makes it clear what actions remain to be completed to deliver the improvements identified by the review. This good practice is not yet used consistently across all board action planning. The outcomes of SCRs are disseminated appropriately in line with a satisfactory learning and improvement framework.

116. The absence of a current and up-to-date early help strategy reflecting recent changes to services means that the board cannot be assured of what is working well locally to ensure that families are receiving the preventative services that they need. A briefing sent to the independent chair from the recently appointed temporary board manager indicates the board's awareness that this task has not been completed, but this had not been actioned before this inspection began. This reflects an omission by the board to deliver this business plan priority, caused by a lack of capacity within children's social care services to undertake the task. Similarly, the board's thresholds document requires updating to reflect changes to early intervention services and to the council's duty arrangements. These include reference to arrangements for children in need under section 17 of the Children Act 1989, which is currently lacking.

117. Strategic oversight of CSE is disconnected and underdeveloped. Information collated by the local authority and provided to the board on the number of children who are at risk of CSE, or of going missing from their family homes or care, is limited and lacks analysis. Information from interviews with children

who have been missing on their return is not used to inform planning to keep individual children and young people safe, nor is it collated and analysed to identify key themes that could help with strategic planning to tackle these problems. Work in this area by children's services and the police is not well-coordinated by partners through the board. Notwithstanding an over-arching strategy on CSE and children going missing, the strategic relationship between the multi-agency sexual exploitation meeting (MASE) the Local Safeguarding Children Board sub-group and the weekly operational meeting is confused and still requires clarification.

118. The board itself has recognised that monitoring of agencies' performance is a particular weakness. Although the council is data rich, too much is unreliable. The board's aspiration has been for its Monitoring, Evaluation, Scrutiny and Intelligence sub-group (MESI) to interrogate these data and present the board with an analysis on particular areas of interest, but this has not been delivered successfully. The result has been that member agencies and the board's sub-committees self-report to both the main board and in the annual report. This does not support an analysis set against agreed performance indicators that would lead to a clear understanding of deficits in frontline practice. As a result, the board was not fully aware of shortfalls in practice identified by this inspection and this is a serious weakness.

119. The board has previously recognised its own underperformance in this area. It put in place a robust performance framework, and the board's independent chair has taken the chair of the MESI on an interim basis to make these improvements. However, this recent arrangement had yet to show impact by the time of this review.

120. The MESI also operates to an annual cycle of audits, the topics for which are identified appropriately by robust board processes such as the challenge log, or to ensure local compliance with newly introduced national requirements. Audit reports are completed satisfactorily, but each generates a separate action plan that adds to the plethora of plans. Agency audits are completed appropriately under section 11 of the Children Act 2004, and considerable effort and energy has been undertaken to ensure the involvement of schools. This has proven time-consuming and the board has now created a separate section 11 sub-group so that the MESI can concentrate on performance monitoring through reports and audits.

121. Recent developments have meant that the board is now creating its own website that is not an adjunct to the council's site as it was previously. This correctly signals the Board's independent status. The board has engaged effectively with young people on the design of the site as part of their commitment to improve engagement with children and young people. However, levels of recognition of the board's activities were low among frontline professionals interviewed by inspectors. The board has already recognised this, and firm plans are now in place to use the website to develop awareness among frontline practitioners of the board's responsibilities for

training, serious case reviews, policies and procedures and other relevant activities.

122. Currently, policies and procedures are not presented in a user-friendly format and further work is needed to ensure that generalised guidance is localised as appropriate. For example, Lewisham's professionals need to know specifically what to do in the event of concerns over a case of suspected female genital mutilation, without needing to contact the NSPCC national helpline.

123. A satisfactory board training strategy leads to a limited programme, delivered mainly by in-house trainers approved under pan-London Safeguarding Board procedures. Training is appropriately evaluated using a newly introduced three-point evaluation methodology. This ensures that high levels of satisfaction on the day are followed up three months later to make sure that the learning has been put into effect. It is too early to evaluate whether this methodology will demonstrate a positive impact on frontline practice. Short lunchtime briefings are particularly successful in delivering the key messages from serious case reviews to busy multi-agency professionals.

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.

The inspection team

Lead inspector: Sean Tarpey

Deputy lead inspector: Ian Young

Team inspectors: Anji Parker, Marcie Taylor, Jon Bowman, Anne Waterman, Tara Geere

Shadow inspectors: Kate Malleson

Senior data analyst: Hywel Benbow

Quality assurance manager: Nicholas McMullen

Any complaints about the inspection or the report should be made following the procedures set out in the guidance *Raising concerns and making complaints about Ofsted*, which is available from Ofsted's website: www.ofsted.gov.uk. If you would like Ofsted to send you a copy of the guidance, please telephone 0300123 4234, or email enquiries@ofsted.gov.uk.

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

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

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

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