London Borough of Lewisham

Inspection of children's social care services

Inspection dates: 8 July to 19 July 2019

Lead inspector: Kate Malleson
Her Majesty's Inspector

Judgement	Grade
The impact of leaders on social work practice with children and families	Requires improvement to be good
The experiences and progress of children who need help and protection	Requires improvement to be good
The experiences and progress of children in care and care leavers	Requires improvement to be good
Overall effectiveness	Requires improvement to be good

Services for children in Lewisham continue to require improvement overall. Services for children in care have deteriorated since the previous inspection in 2015, when they were judged to be good. Internal and external evaluations of children's services in 2018 have resulted in widespread and fundamental changes. This work is being overseen by an improvement board, underpinned by strong political and corporate support and a re-invigorated senior management team. Senior managers are clear about the changes that are required, and the pace of improvement has accelerated since the appointment of the director of children's social care in September 2018.

Senior managers rightly focused initially on children at the highest level of risk. However, this has meant that early help services are still underdeveloped, and some recommendations from the previous inspection have not been fully implemented. Most children in care are in appropriate placements, although formal matching has sometimes been slow. Social workers know children well and visit them regularly. However, the quality of social work practice is still too variable.

What needs to improve

- Early help services, together with partners, so that children and families receive timely and appropriate help when needs or concerns are first identified.
- Services for children and families when domestic abuse has been identified.
- The quality and consistency of social work practice in assessment and planning, underpinned by high-quality supervision and oversight.
- Recording systems for the oversight of allegations against professionals and carers.
- The quality of recording, supported by a stable and reliable electronic case recording system.
- Services for children in care, including achieving permanence, completing life-story work and consultation with other local authorities before placing children at a distance.
- Practical support and the provision of health histories for care leavers.

The experiences and progress of children who need help and protection: Requires improvement to be good

1. Early help services remain underdeveloped, despite this being a recommendation at the previous inspection. When children do receive a service, the assessments are weak and do not include basic information, such as the reason for the assessment. The lack of capacity in the service, which is externally commissioned, means that children and families may have to wait for up to two months to receive help. Management oversight of the waiting list at the time of the inspection was not sufficiently rigorous. Senior managers immediately reviewed all of the cases and found that a small number of children needed a statutory service, and that the circumstances of others had deteriorated while they were waiting. Management oversight has now been strengthened, both internally and with the external provider, and links have been made to social care teams. These changes increase opportunities to ensure that thresholds are accurately applied. In addition, a variation to the contract has increased the capacity of the externally commissioned service, allowing a gradual reduction to the waiting list.

2. Most children receive a timely service at the point of referral and there have been some improvements since the focused visit in September 2018. Most processes are working better, workflows are smoother, and work is more manageable. Consent is explored and recorded, and overridden when appropriate. Managers are increasingly using performance information to

better target improvement activity, to analyse decision-making and to assess the impact of threshold revisions, both internally and with partner agencies.

3. The co-location of police, health and education partners within a confidential space and the introduction of daily information-sharing meetings have increased partner confidence and enhanced the understanding of children's needs when they are referred for help. These improvements add value to decision-making at the 'front door'. Schools appreciate the enriched communication with the multi-agency safeguarding hub when they have concerns about children. They are becoming more confident in understanding the recently revised thresholds, leading to more appropriate referrals.

4. Appropriate and timely action is taken on referrals regarding children who are suffering or are likely to be suffering significant harm. This includes children who need a service out of hours. However, for some children who managers deem to be at lower risk, decision-making takes too long.

5. Child protection enquiries are timely and children are seen promptly. Risk is recognised and effective multi-agency information-sharing helps to ensure that children's circumstances are understood; this leads to appropriate decision-making. Most strategy discussions are timely and partner agencies are consulted, although they are not always in attendance. Minutes of strategy discussions are sufficiently detailed to demonstrate that historical concerns are considered, as well as current risk and protective factors, in order to inform decision-making.

6. Timely screening of police notifications leads to prompt recognition of domestic abuse. However, the response to children and families in these circumstances is not sufficiently robust and the options for support are not clear. Risks presented by male partners in relation to current and ongoing domestic abuse are not always fully assessed, analysed or addressed. Case records show that a small number of children continue to feel scared of the men coming to their home because of apparent parental collusion, which has not been recognised or addressed.

7. The quality of assessments is variable. A structured tool is used well in stronger assessments to understand risks, strengths and protective factors. In weaker assessments, there is too much description and insufficient analysis. While ethnicity, culture and faith are stated, their importance and impact on children's identity and experiences are not consistently explored.

8. Assessments are undertaken at an appropriate point for unborn babies. However, the quality is inconsistent as they do not always include a complete chronology of family history to inform risk assessment and decision-making. Assessments also demonstrate an overly positive view of parental ability to make the necessary changes to meet the needs of their babies.

9. Children in need and subject to child protection plans are regularly visited by social workers, who know their children very well. Social workers undertake purposeful work, although the recording does not fully reflect the quality of work being undertaken. Children are seen, and mostly seen alone, and their experiences mostly inform plans and decision-making.

10. Child protection and child in need plans are not sufficiently detailed and do not help families to understand what needs to change to improve circumstances for their children, or what will happen if these changes are not made. As a result, some children make insufficient progress and remain on plans for too long. Some cases have been closed prematurely, or stepped down to early help, despite the capacity issues in early help services. This has led to children being re-referred because changes have not been embedded or sustained. An over-reliance on written agreements with parents and carers has been recognised and is being addressed, as expectations have been unrealistic and agreements have been ineffective.

11. Multi-agency core groups meet regularly to consider children's progress. Use of a structured social work tool is helping professionals to state more clearly the changes needed and the timescale for change. The tool is also beginning to support the measurement of progress. However, not all plans are written using language that parents can easily understand.

12. The pre-proceedings element of the Public Law Outline is properly initiated in response to concerns. The access to resources panel provides oversight and a clear rationale for next steps, and children's cases are appropriately stepped down when there is evidence of change. However, in a minority of cases, children continue to experience drift and delay and their circumstances do not improve quickly enough because planning is unfocused and uncoordinated. The quality of letters before proceedings is variable. Stronger letters clearly outline the concerns and risks and the steps which parents need to take to address them.

13. Allegations against professionals and carers are treated seriously. Thresholds are appropriately applied when allegations are made and there is effective work with police to consider and address concerns. However, recording systems and processes for maintaining oversight are unwieldy. Records of conversations that do not lead to referrals are not maintained and so patterns of low-level concerns may not be identified.

14. Social workers feel well supported by their team and their managers. However, supervision and management oversight are not consistently regular and there is limited evidence of reflective practice. Managers and social workers describe informal and important conversations which are not recorded. Supervision actions are not always specific, time-bound or challenging, and follow up and monitoring of progress for children are poor.

15. Private fostering is promoted effectively, and the dedicated worker has good links with the communications department and partner agencies through the current safeguarding arrangements. This leads to timely initial visits, detailed assessments and appropriate checks and oversight of private fostering arrangements. Children are visited regularly, and there is appropriate liaison with a range of relevant agencies. The views of children and their parents are well considered.

16. Services for 16- and 17-year-olds at risk of homelessness are strong. Young people benefit from being well supported, whether they choose to become accommodated or to live independently.

17. Disabled children in need of help and protection benefit from effective services. There is sensitive consideration and understanding of the needs of children and families by knowledgeable social workers, who are aspirational for their children. Social workers demonstrate a good awareness of the increased risk of abuse for these children because of their additional vulnerabilities. The well-trained team undertakes regular direct work with children and their families using a range of communication methods. This informs assessments and plans, and, as a result, the lives of disabled children are improving.

18. When children and young people are identified as being at risk of criminal or sexual exploitation, appropriate action is taken to reduce risk. A recent review of the different teams involved in this work has led to the development of a more integrated offer, but it is too early to see the impact of the new arrangements. Risks to children, for example risks from radicalisation or female genital mutilation, are identified well. However, a small number of children continue to be exposed to ongoing risk and harm as a result of an overly optimistic view of parental willingness and capacity to protect their children from risks presented by other family members.

19. Processes for recording, tracking and sharing information about missing children and young people are robust. Information is obtained from other local authorities when they place children in the borough and these children are also discussed and considered at the serious youth violence or missing, exploited and trafficked panels. However, the completion of return home interviews for Lewisham children is not consistent, and this means that the experiences and the risks that some children face are not fully understood.

20. Staff are tenacious in tracking and following through all reported cases of children missing education. They gather soft intelligence from key partners, and, as a result, they successfully resolve most cases and ensure that children are protected.

21. Monitoring arrangements for assessing the quality of provision for children who are electively home educated have improved over time. As a result, staff

are better able to provide appropriate challenge and support, and to identify safeguarding issues and make referrals to social care when necessary.

The experiences and progress of children in care and care leavers: Requires improvement to be good

22. Most children come into care in a timely way, and thresholds for entry to care are clear. However, children who return home from care do not consistently benefit from purposeful planned work. This means that some children experience the disruption and anxiety of repeated care episodes.

23. Staff are not always clear about the difference between a family arrangement and a 'connected carers' placement. This means that the suitability of the placement is not fully assessed in accordance with statutory guidance. Plans are in place to improve practice, but it is too early to see the impact of these.

24. Children benefit from a wide range of appropriate placements where their needs are mostly well met, although permanence is not always secured in a timely way. Many children in long-term foster placements, sometimes for many years, have not been matched at panel. Inspectors found examples of children who had not benefited from a sense of permanence, or whose placements had broken down. Additionally, life-story work is underdeveloped, limiting children's understanding of why they are in care and why they are not able to live with their families.

25. When children are placed at a distance from the local authority, notification takes place to ensure that host local authorities are made aware of the children placed in that area. However, notifications are not always timely and there is no consultation with host authorities before children are placed. This is a weakness. Some children had not received timely and appropriate support and services as a result of the absence of consultation.

26. Unaccompanied asylum-seeking children receive an effective service, and their individual needs are well considered. Health assessments and education are prioritised, therapeutic services are available and timely legal support is provided to assist with immigration issues. They live in safe and suitable accommodation according to their individual requirements. As a result of the comprehensive support that they receive, most make progress and settle well.

27. Children in care are visited regularly by social workers who know them well, although this is not always captured effectively in case records. In stronger examples, children's voices are clear and there is evidence of strong, trusting relationships between social workers and children. Children have access to advocates, independent visitors and mentors where appropriate.

28. While plans for children in care demonstrate monitoring, oversight and escalation by independent reviewing officers (IROs), the impact is limited in

many cases. Reviews are timely, and the use of participation tools helps to ensure that children's wishes and feelings are captured; in stronger examples, this appropriately influences their plans. Children told inspectors about the good range of activities and leisure opportunities that enable them to enjoy life.

29. The virtual school is a considerable strength and is led and managed very effectively. Children from Reception to key stage 4 make strong progress in their learning. The pupil premium plus funding is used creatively to support children's personal development and well-being. A small minority of personal education plans fall short of the required standard because they do not capture adequately the full journey of the child. Leaders acknowledge that further work is needed to embed recent improvements in the quality of provision for children in care who are post-16.

30. The well-targeted work of the 'dream, achieve and believe' team, a collaboration of the virtual school and child and adolescent mental health services (CAMHS), is having a strong impact on improving children's social, emotional and mental health. Children's physical and mental health needs are routinely and well considered, and this includes their emotional well-being.

31. The adoption service is effective and the processes for recruiting and approving adopters are timely. Adopters are robustly assessed, carefully matched with a child and prepared well. Plans for adoption are mostly achieved within the child's timescale. There is a lack of performance monitoring and it is difficult to monitor trends and patterns because the adoption service only keeps paper files.

32. The fostering service is improving from a low base. There is a clear fostering recruitment strategy to increase the number of local foster carers. The fostering panel is effective in discharging its duties. The introduction of the role of the panel adviser is providing an additional layer of quality assurance. This has had a positive impact on the quality of assessments of suitability of prospective foster carers. Many positive changes have been implemented, such as the provision of out-of-hours fostering support, an online training hub and a dedicated IRO with oversight of foster carers' annual reviews. However, these changes are very recent and it is too early to evaluate their impact.

33. The leaving care service is improving slowly. Capacity has been increased so that personal advisers now have lower caseloads. Changes are underpinned by a clear improvement plan that includes ensuring that care leavers have an up-to-date pathway plan with clear actions about what needs to be done and by whom, and the recruitment of qualified social workers to hold complex high-risk cases. Care leavers are clear about their entitlements and access to advocacy services.

34. Most care leavers live in suitable accommodation and there has been a rise in the number of 19- to 21-year-olds in education, training and employment. This includes an increase in the number of young people attending higher education beyond A level.

35. Care leavers told inspectors that although they receive help with budgeting skills, they would like to have more practical support with basic tasks when setting up their homes. In addition, care leavers are not routinely informed of their health histories.

36. The children in care council and recently relaunched care leavers' forum are starting to have a positive influence on service developments. Young people talked about how they had influenced recruitment through interviewing social workers, and the 'In my shoes' training that they are delivering to staff.

The impact of leaders on social work practice with children and families: Requires improvement to be good

37. Leaders and managers are implementing widespread improvement activity and whole-system cultural change, supported by an improvement board chaired by the lead cabinet member. This follows a number of internal and external evaluations in 2018 that identified a lack of pace and insufficient impact of work to improve children's services.

38. Importantly, the pace of improvement has significantly accelerated since the appointment of the director of children's social care in September 2018 and the establishment of the improvement board. The lead cabinet member has brought a fresh perspective and a determination to prioritise the needs of children by engaging corporate support and identifying increased resources. Improvements are increasingly evident, but some are at an early stage.

39. Corporate parenting has been re-invigorated. The wide-ranging improvement plan includes improved scrutiny and challenge and a commitment to listening meaningfully to the voices of children in order to develop services. However, it is too recent to see the impact of these plans on services for children.

40. The judiciary and Cafcass commented positively on the effectiveness of professional relationships and the responsiveness of staff. Court proceedings are completed in a timely way and partner agencies describe a growing confidence as a result of the improvements being made.

41. A layer of management that had previously been removed has now been reinstated. This is designed to provide additional capacity for strategic development and to increase the pace of improvement. Other recent senior appointments are helping to tackle the weaknesses and implement the changes that are required to raise the quality of social work practice.

42. A recently introduced strengths-based social work model is ensuring that children are increasingly at the centre of practice. Practice standards are being developed following on from this work.

43. Leaders and managers took immediate and appropriate action to review the early help waiting list when inspectors found a small number of cases where thresholds had not been correctly applied. Managers are aware of the extent of work needed to develop and embed an effective early help offer and this is part of the improvement plan.

44. A recent audit of decisions at key transfer points across the system has provided the local authority with assurance that threshold decisions are accurate, and that most children are receiving services at the appropriate level of intervention. Inspectors also found this to be the case. Senior managers are continuing to monitor threshold decisions closely in order to ensure that children are protected and continue to receive effective intervention. Current casework audits are overly positive and do not sufficiently consider the quality of the work or whether practice is child-focused. The quality assurance framework is comprehensive but relatively new and therefore it is not yet fully embedded.

45. The electronic case recording system has been redesigned and now provides a range of useful performance information. Managers at all levels are starting to learn how to use this information to evaluate and improve services for children. However, the quality of data in some performance reports means that they are not yet sufficiently reliable to support progress monitoring and accurate financial planning.

46. Despite some improvements, the electronic recording system is subject to frequent system failures, which impact on the ability of staff to record effectively and to complete their tasks in a timely way. This means that records may not be up to date, recording takes a disproportionate amount of time, and performance information may be inaccurate.

47. Senior managers are aware that commissioned services such as early help and placements for children in care are not consistently delivering effective services for children and their families. Further work is being undertaken to ensure that the right services are in place to meet the needs of children in Lewisham.

48. Additional social work capacity has reduced caseloads, although these are still too high in some areas. Reducing caseloads has enabled social workers to build stronger relationships with children and undertake more direct work.

49. The training and professional development of social workers have not received a high priority. However, more recently there has been an appropriate focus on developing the workforce so that they can provide better

quality basic social work. Newly qualified social workers are well supported during their first year in employment and have protected caseloads and regular supervision.

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

If you would like a copy of this document in a different format, such as large print or Braille, please telephone 0300 123 1231, or email enquiries@ofsted.gov.uk.

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

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

Piccadilly Gate
Store Street
Manchester
M1 2WD

T: 0300 123 1231
Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
W:www.gov.uk/ofsted