London Borough of Lambeth

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: 24 February 2015 – 18 March 2015

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The overall judgement is that children's services are inadequate
There are widespread or serious failures in the delivery of services for looked after children which result in their welfare not being safeguarded and promoted. Leaders and managers have not been able to demonstrate sufficient understanding of failures and have been ineffective in prioritising, challenging and making improvements in relation to looked after children services. It is Ofsted's expectation that, as a minimum, all children and young people receive good help, care and protection.[2]

The judgements on areas of the service that contribute to overall effectiveness are:		
1. Children who need help and protection		Requires improvement
2. Children looked after and achieving permanence		Inadequate
	2.1 Adoption performance	Inadequate
	2.2 Experiences and progress of care leavers	Requires improvement
3. Leadership, management and governance		Inadequate

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

[2] A full description of what the inspection judgements mean can be found at the end of this report.

Contents

The local authority

Summary of findings

Children's services in Lambeth are inadequate because:

Leadership and management

- A failure of leadership has resulted in the deterioration of almost all safeguarding services and services for looked after children and their families in Lambeth from when they were last inspected by Ofsted in 2012.
- Performance information is poor or not available. Leaders and managers at all levels do not have the information that they need to manage or oversee practice effectively.
- Significant changes in management and social work staff at all levels in recent years have resulted in a lack of continuity, poor engagement with some service users and reduced standards of social work provision and management oversight.
- From the latter part of 2014, leaders and managers have demonstrated an improved understanding of the failures in key services and have effected improvements in some areas. However, an over-optimistic evaluation of the performance of these services, provided for this inspection, does not demonstrate a realistic understanding of the challenges faced.
- Strategies to tackle child sexual exploitation have been developed with partners, but these are not consistently underpinned by robust practice. For example, children missing from care are not routinely interviewed on their return, so risks are unexplored.

Quality of practice

- Social work practice is not robust and, in too many cases, assessments and plans are not of a good enough quality.
- Too many changes of social workers and managers mean that plans to reduce harm and to promote the welfare of children and young people have been subject to drift and delay.
- Weak management oversight has led to poor practice not being challenged and children's needs being unmet. This is particularly the case for children who would benefit from being adopted.
- The needs of looked after children are not well met as a result of poor permanency planning, insufficiency of local placements, frequent changes of social workers and delays in initial health assessments.

What does the local authority need to improve?

Priority and immediate action

1. Ensure that all young people who go missing from home and care are promptly and appropriately seen upon their return, and that the resulting information is used effectively to reduce risk, including risk of sexual exploitation, to them and to other young people.

2. Ensure that accurate data and performance management information are collected, collated and analysed, and that this is used by managers, staff and elected members to evaluate and improve the quality of services to vulnerable children and young people.

3. Ensure that all children who require adoption receive a timely service and that this is guided by a comprehensive adoption strategy and action plan, with clear targets to improve the quality of service.

4. Ensure that all relevant agencies are consulted and contribute to planning during child protection enquiries.

5. Ensure that there is no undue delay in children moving to permanent homes. This includes establishing effective use of the Public Law Outline in achieving timely outcomes for children and young people.

Areas for improvement

Safeguarding children

6. Ensure that all child protection plans and child in need plans clearly identify key actions in order of priority, have clear timescales for their completion and contain explicit contingency plans to escalate intervention if progress is insufficient.

7. Ensure that the progress of child protection and child in need plans when reviewed in meetings and in supervision is focused on the reduction of risk.

8. Ensure that the consistency of recording, frequency of visits and quality of social work practice within the disabled children's team are of a high standard.

Quality of practice

9. Ensure that all social work staff and managers are clear about what is expected in terms of the quality of their practice, so that children and young people receive a timely and effective service.

10. Ensure that looked after children receive initial health assessments promptly.

11. Ensure effective quality assurance of all written and verbal material presented to the adoption panel.

12. Ensure that good quality life story work is developed for children and young people, so that they understand what has happened in their lives.

13. Ensure that all care leavers have access to their health histories, and are informed of their rights and entitlements.

14. Ensure that all care leavers have up-to-date pathway plans which are outcome focused and are specific and measurable, in particular in relation to their education, employment and training.

Leadership, management and governance

15. Ensure that there are sufficient experienced social workers and managers who are able to provide consistent and sustained high quality support and intervention to improve outcomes for children and young people.

16. Ensure that the local authority has accurate data and information that are used effectively to manage and monitor the progress of children who require adoption.

17. Ensure that quality assurance information is routinely captured by managers at all levels, including through undertaking case audits, and that this is effectively used to improve casework practice and to manage and develop services.

18. Ensure that all staff receive regular, high quality supervision in accordance with the local authority policy, and that this is regularly monitored.

19. Ensure that feedback from the adoption panel chair is fully considered by managers and is acted upon to improve adoption practice.

20. Ensure that the profile of the location of placements for looked after children is understood, so that sufficient foster carer and children's home placements can be provided to enable looked after children to live near to their home when it is in their best interest.

21. Ensure that the Corporate Parenting Panel effectively scrutinises outcomes for all looked after children and care leavers.

22. Work with health partners to ensure that children and young people in need of child and adolescent mental health services receive a timely service.

The local authority's strengths

23. The local authority and partner agencies work well together to provide good, early, targeted support to children and families, including those with complex needs. The common assessment framework is well established, with wide engagement from partner organisations.

24. The local authority and partner agencies work well together to prevent young people from being drawn into gang activity; their success in diverting some high risk gang members is effectively reducing risk to some children.

25. Multi-agency responses to domestic abuse are effective and, as a result, repeat victim rates are low.

26. The multi-agency safeguarding hub and the First Response service work in close collaboration with key partners.

27. Educational support for children missing from education is good and the virtual school is working well with a range of education partners to support the educational needs of looked after children.

28. Young people are able to have their views heard and to contribute to the development of some of the services that impact on their lives.

Progress since the last inspection

29. The last Ofsted inspection of Lambeth's safeguarding arrangements was in May 2012. The local authority was judged to be outstanding. This inspection has found that there has been significant deterioration in all areas.

30. The last Ofsted inspection of Lambeth's services for looked after children was in May 2012. The local authority was judged to be outstanding. The key recommendation for the local authority was to extend the positive development and influence of the virtual school beyond the age of 16 to increase participation in high-quality education and training opportunities and raise the achievement of care leavers further. This has been achieved in part, although education, employment and training opportunities for care leavers remain limited.

31. The last Ofsted inspection of Lambeth's adoption service was in April 2012. The service was judged to be outstanding. The quality of adoption services, standards of practice, timeliness and management oversight have significantly deteriorated.

32. The last Ofsted inspection of Lambeth's fostering service was undertaken in December 2012. The service was judged to be outstanding. The fostering service has not sufficiently developed or progressed since that inspection.

33. Since their last inspections, all of the above services have significantly deteriorated in performance, in the standards of social work practice and in the robustness of management oversight and direction. This has been in the context of high numbers of staff changes across all levels of management and practitioners.

34. Recognition of, and concerted efforts to tackle, the deteriorating standards of practice and management oversight are evident towards the latter end of 2014. Corrective action to raise the standards of social work practice is beginning to have a positive effect in some areas.

35. Some key services have been developed, such as an enhanced and better-targeted range of early help provision, and the multi-agency safeguarding hub.

Summary for children and young people

- Services that help vulnerable children and young people, including those who are looked after by the local authority, have deteriorated since they were last inspected in 2012.
- Services work well together to provide help quickly for children and their families in Lambeth when problems first arise.
- When there are concerns about children, for example because of gangs or bullying, social workers work hard to keep them safe. However, children sometimes have several changes of social worker, and this means that plans may get delayed. When this happens, not all children get the right support at the right time.
- When children go missing, everyone works hard to make sure that they are found. However, when children return they don't always get to talk to an independent person about the reasons why they ran away. This means that social workers are not able to assess the risks to children properly.
- Children and young people who need specialist support from mental health services have to wait too long to be assessed. This means they don't get help quickly enough with the things that are troubling them.
- Children who cannot live with their own families are found other places to live, but sometimes it takes a long time to find permanent new homes for them. There are not enough foster carers in Lambeth, which means that children are often placed outside the area, although most of them live within 20 miles of their families.
- Children who are looked after by the local authority get a lot of encouragement to do well at school. This is very important as it helps them to make good progress and means that they can make sound choices about what they want to do.
- Most young people who leave care live in suitable housing and they get help to learn how to live independently. Quite a few care leavers get good support to go to university. However, if they want to do an apprenticeship or get a job, there is less help available.
- Young parents in Lambeth get good support from specialist services that help them to prepare for and care for their baby. They also get help and support to get back into education and to manage family life.
- Children and young people told inspectors that Lambeth Council listens to them and takes their views seriously. They also said that they are encouraged to get involved in deciding what services they need locally.

Information about this local authority area[3]

Children living in this area

- Approximately 61,900 children and young people under the age of 18 years live in Lambeth. This is 19.7% of the total population in the area.
- Approximately 31% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 30.6% (the national average is 17%)
  - in secondary schools is 30.8% (the national average is 15%).
- Children and young people from minority ethnic groups account for 75% of all children living in the area, compared with 22% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Black African, Black Caribbean and mixed ethnic groups.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 52.1% (the national average is 19%)
  - in secondary schools is 42.9% (the national average is 14%).

Child protection in this area

- At 31 December 2014, 1,984 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 2,192 at 31 March 2014.
- At 31 December 2014, 307 children and young people were the subject of a child protection plan. This is a reduction from 358 at 31 March 2014.
- At 31 December 2014, 11 children lived in a privately arranged fostering placement. This is a reduction from 16 at 31 March 2014.

Children looked after in this area

- At December 2014, 482 children were being looked after by the local authority (a rate of 78 per 10,000 children). This is a reduction from 534 (87 per 10,000 children) at 31 March 2014. Of this number:
  - 367 (or 76%) live outside the local authority area

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

- 31 live in residential children's homes, of whom 97% live out of the authority area
- three live in residential special schools[4], of whom 100% live out of the authority area
- 353 live with foster families, of whom 76% live out of the authority area
- four live with parents, of whom 50% live out of the authority area
- 19 children are unaccompanied asylum-seeking children.

- In the last 12 months:
  - there have been 22 adoptions
  - 36 children became subjects of special guardianship orders
  - 324 children ceased to be looked after, of whom 14% subsequently returned to be looked after
  - 12 children and young people ceased to be looked after and moved on to independent living
  - 77 children and young people ceased to be looked after and are now living in houses of multiple occupation.

Other Ofsted inspections

- The local authority does not operate any children's homes.

Other information about this area

- The Director of Children's Services has been in post since 1 December 2014.
- The chair of the LSCB has been in post since February 2013.

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

Inspection judgements about the local authority

Key judgement	Judgement grade
The experiences and progress of children who need help and protection	Requires improvement

Summary

Children identified as at high levels of risk of child sexual exploitation or gang related activity are considered regularly at multi-agency meetings. Rigorous scrutiny of known information is used to make plans and to provide services designed to reduce their vulnerability. However, responses to children who go missing or absent from home or care lack rigour. The increased vulnerability to all forms of exploitation for this group of children is not well addressed by frontline staff and managers. Children are not visited systematically when they return after going missing. The analysis of individual triggers and patterns of behaviour is insufficient to be used effectively to reduce risk. Inconsistency in recording of missing episodes makes it difficult for the local authority to collate and analyse data in relation to wider patterns and trends.

Children in Lambeth receive good quality early help from a wide range of agencies, when they need it. This includes targeted support for children and families who have complex needs. For some, this prevents problems from getting worse; for others, it ensures that previous problems that necessitated social work support do not recur.

The local authority provides an efficient and timely response when concerns about a child are first identified. Information sharing between partner agencies is well co-ordinated through the multi-agency safeguarding hub. This, together with readily available social work advice through the local authority's First Response teams, is helping to reduce the number of children who are inappropriately referred to children's social care.

Children who are assessed as requiring a social work service as children in need are generally visited regularly, offered services, and their plans reviewed at multi-agency meetings. Meetings do not always consider sufficiently whether intervention has resulted in positive change for children.

When children are considered to be at risk of significant harm and are made subject to a child protection plan, social work visits, child protection conferences and core group meetings do not always focus sufficiently on key issues or whether the level of risk is reducing. Alternative actions, including pre-proceedings agreements, are not always considered quickly enough. This means that some children continue to live in circumstances that are harmful and neglectful for unacceptable periods of time.

Turnover of staff has led to inconsistent and sometimes poor social work practice with some children, particularly in the disabled children's team.

36. Early help provided by the local authority and its partners is strong. Early intervention staff confidently support families and young people from birth to young adulthood. Early help interventions are well co-ordinated by two multi-agency teams (MATs) which, at the time of the inspection, were supporting 500 families per annum. The MAT panel offers additional oversight and quality assurance of early help assessments under the common assessment framework (CAF) and on the application of thresholds.

37. Inspectors saw examples of step-up and step-down processes being used appropriately. There is a high use of the CAF (699 between April and September 2013), with 93 children receiving a service 'stepped down' from children's social care. The CAF is well used by a wide range of partners including schools, health visitors, children's centre outreach workers and MAT workers. As a result, children with complex needs are offered a range of timely and effective services that, in many cases, prevent problems escalating or recurring. The Aspirational Lambeth Families (ALF) project is successful in helping families with multiple complex problems, with 1080 families 'turned around' and 238 of these worked with directly by the ALF team. This makes Lambeth one of the highest performing authorities in London for their work with 'troubled families'.

38. Children's centres offer a range of support to very young children and their families, including those with multiple and complex needs. The family nurse partnership works alongside the voluntary sector to provide bespoke wrap-around care for young teenage parents. This work helps teenagers to become more confident parents and to improve their housing and living conditions, and eventually assists them to return to education or secure employment. As one 15-year-old expectant father told inspectors, 'I no longer feel alone and I am excited about becoming a dad.'

39. Thirty-two newly trained commissioners from The Young Lambeth Co-operative have recently commissioned a range of services to support young people aged 11 to 19 across the borough. These include: play and targeted youth work projects, refuges to support children exposed to domestic violence, group drama sessions, and sports activities, focusing on young people at risk of gang violence and sexual exploitation. Although this innovative project has much potential to change young people's lives, it is too soon to determine its impact.

40. Early help managers have accurately identified some gaps in services, notably for perpetrators of domestic violence and male victims of sexual exploitation. Also, the waiting lists for child and adolescent mental health services of eight months for initial assessment and treatment are far too long.

41. The multi-agency safeguarding hub (MASH) is an efficient first point of contact when there are concerns about a child. MASH partners have well-established protocols for information sharing and obtaining consent, which are applied appropriately. A recently refreshed, draft multi-agency threshold document is used by children's social care services to ensure consistency in decision making

and application of thresholds. This, combined with the introduction of a new multi-agency referral form and readily available advice from the local authority's recently established First Response team, is beginning to improve the effectiveness of information sharing. The number of inappropriate contacts to children's social care, while reducing, remains high, although it is difficult to confidently secure accurate figures from local authority data. According to local authority data from January 2015, notifications from the police constituted an average of 30% of all contacts, of which 81% resulted in signposting to other agencies or no further action.

42. Inspectors saw a small number of inappropriate contacts and referrals that had been made to children's social care by partner agencies and others that had not been referred quickly enough. The local authority recognises that more needs to be done to ensure that thresholds are consistently understood and applied by all agencies. Targeted work has been undertaken with some groups, such as general practitioners, to improve the quality of referrals.

43. In cases seen by inspectors, decisions by First Response to progress to a referral or to close a contact were proportionate and made at an appropriate level. In the majority of cases, the rationale for decisions was clearly recorded and was shared with the referrer. When inappropriate referrals were made by partner agencies, First Response dealt with them efficiently by signposting them to more appropriate services.

44. The newly introduced multi-agency referral form is comprehensive. It uses the Signs of Safety model to assist partners to clearly outline their concerns. However, it is not yet widely used. Partners continue to use two older referral forms, which demonstrate that they are not fully aware of new processes. First Response ensures that this confusion does not cause avoidable delay to children if sufficient information is provided on older forms to enable them to make decisions on action required.

45. Action taken to prevent problems re-emerging is effective, including signposting to early help. Unvalidated data indicate that in 2013 re-referral rates were 13%, which was significantly better than for statistical neighbours and the England average of 23% for 2013–14.

46. When children require an assessment of need or are the subject of child protection enquiries, work is transferred to Children and Families Teams. There are no unallocated cases within these teams and transfer of work is generally timely. However, in a small number of cases seen by inspectors, there was delay in assessing children's needs, providing them with services, and making appropriate initial plans.

47. When there are concerns that children may be at risk of significant harm, almost all initial strategy discussions are by telephone between the police Child Abuse Investigation Team (CAIT) and children's social care. Although other agencies were consulted during the child protection enquiries that followed,

opportunities for them to contribute at the planning stages were missed. Although no cases were seen where children were placed at risk as a result of this practice, it is not compliant with guidance published in *Working Together 2013*.

48. Decisions on whether enquiries should be conducted jointly by the local authority children's services and the police or be undertaken by one agency are based on a sound analysis of potential risk. Child protection enquiries are thorough and included consultation with other agencies. Children are seen alone when of an appropriate age, and younger children are observed. In almost all cases seen, appropriate conclusions to enquiries were reached and actions taken were proportionate. In cases where the decision was not to proceed to an initial child protection conference (ICPC), child and family assessments were completed and efforts were routinely made to engage families in step-down services, either for children in need or for early help, albeit with limited success.

49. The emergency duty team provides an out-of-hours service, staffed by suitably qualified and experienced social workers who have access to managerial guidance and legal support. Changes to the service as a result of lessons learnt from a recent local serious case review have improved the timeliness of responses to callers and communication with daytime staff. The service does not have the capacity to undertake non-urgent work. Current arrangements are sufficient, due to the priority given to children's services and the flexibility of the workforce at periods of high demand.

50. Children in need and child protection assessments seen contained a clear statement about the reason for the referral; information was appropriately shared with parents and with partner agencies. A range of appropriate services is offered during the course of assessments. The quality of assessment, including those for early help, was variable. Most required improvement, where the analysis did not sufficiently consider the balance of risk and protective factors and the significance of the case history. A small number of assessments showed very strong analysis, with careful and thorough consideration of case history and relevant research. Managers set initial timescales for the completion of assessments, based on the complexity of the case. Although some assessments were completed within shorter timescales, these were not always linked to the assessed needs of the children and young people. In most of the cases seen, the resulting plans were not sufficiently clear about changes required that would make a difference for children, and did not identify the timescales for change.

51. Recommendations to progress to an ICPC are appropriately considered by senior managers. All requests are submitted to the Head of Service, whose analysis in cases seen showed a detailed understanding of the cases, underpinned by reference to research.

52. Child protection conferences are generally timely and are well attended by relevant agencies. Figures provided by the local authority for April 2014 to January 2015 indicate that 82% of initial conferences and 100% of review conferences were held within timescales. Conferences observed by inspectors were effectively chaired by suitably experienced and knowledgeable staff. Information sharing was robust and focused on children's needs, based on the Signs of Safety model. The quality of child protection plans seen by inspectors was not robust, often detailing actions without prioritising the key changes needed to reduce risks to the child. However, some more recent plans seen were clearer, and explained to parents what needed to change and the likely consequences if this was not achieved.

53. Core groups are generally held within or close to timescales set by child protection conferences. Their effectiveness is too variable as they do not consistently consider if the risk to the child is reducing. Meetings too often simply update whether actions have been completed, rather than assessing the difference that work undertaken has made to children. Child protection conferences remain the main medium for driving plans forward. This has been recognised by the local authority, who plan to introduce a mid-period review by chairs to ensure that plans are progressed between conferences.

54. Child in need plans are generally not sufficiently specific about timescales for change, issues are not prioritised, and few contain a rigorous analysis of the impact of the work undertaken. However, inspectors did see some examples of effective multi-agency work done with children subject to child protection plans and children in need plans that assisted parents to make the necessary changes to improve outcomes for their children.

55. Children in need of help and protection who also have complex needs arising from a disability receive a service from a dedicated disabled children's team. Turnover of social workers and managers in this team has been considerable in recent years, which has had a negative impact on the continuity and quality of the support provided. Inspectors saw gaps in the frequency of statutory visits to children, case records were often incomplete, and a small number of workers spoken to were struggling to get to know all the children on their caseload. As a result, contact with those children was ineffective as staff lacked a full understanding of the family history and had not yet formed a meaningful relationship with the children, many of whom have communication difficulties. In cases seen, all children had been visited recently.

56. Children in need and those subject to child protection plans are routinely seen alone during assessments and on child protection or child in need visits to their home or school. Time is spent talking to children about their day-to-day activities and their wishes and feelings. Some evidence was seen of the use of direct work tools with younger children, although this was not widespread. Examples were seen of social workers demonstrating sensitivity and skill in engaging children in difficult conversations. Interaction with children was not always sufficiently focused on the causes of concern, and the purpose of visits

was not always clear. In a small minority of cases seen by inspectors, workers had extensive contact with children without ever discussing the key reasons for their involvement.

57. Managerial oversight and decision making within casework are clearly and routinely recorded on the local authority's electronic systems, including input by senior managers. The quality of this recording is not always sufficiently analytical or reflective, and reasons for not choosing alternative courses of action are rarely explained.

58. In many cases, children and families experienced multiple changes of worker due to staffing issues, and this resulted in drift and delay in implementing plans to support them. In some cases that have been subject to child protection plans for some time, a lack of parental engagement or disguised compliance, while recognised, was not acted upon quickly enough. This has resulted in children remaining subject to child protection plans that were ineffective for unacceptable periods of time. Recently, managers have taken a more robust response in these cases, using pre-proceedings agreements under the Public Law Outline (PLO) if there is continued lack of progress. In a minority of cases, this has resulted in more effective engagement by families.

59. The child protection tracking panel introduced in December 2014 has yet to show sufficient impact in reducing the number of children who remain subject to child protection plans for long periods of time. Local authority unvalidated data for January 2015 indicates that the percentage of children subject to plans for over two years is 7.5%, a 50% reduction from the 2013–14 figure of 15%. However, this remains significantly higher than the England average (2.6%) and the Inner London average (4.5%) for 2013–14.

60. Children's views are collated through consultation documents and sometimes chairs meet them outside the conference to obtain their views. However, few children attend their conference and their participation in conferences is underdeveloped. Advocacy is not routinely provided or actively considered for children subject to child in need or child protection plans and children are not consistently encouraged to attend reviews. As a result, children's participation in these meetings is low.

61. Inconsistencies within the reporting of data used by the local authority undermine its ability to have a fully accurate picture of its own performance in safeguarding children. The local authority's prevalence data as of January 2015 in relation to child protection plans show that the highest number of children are subject to plans due to neglect (200), followed by emotional abuse (146), physical abuse (30) and sexual abuse (7). Domestic abuse is a feature in 70% of cases, as reported in the LSCB annual report 2013–14.

62. Multi-agency arrangements for the consideration of high risk domestic abuse cases are strong. Inspectors saw examples of robust risk assessments completed by commissioned services, which provide support for victims of

domestic violence, using the co-ordinated action against domestic abuse (CAADA DASH) risk assessment tools.

63. A multi-agency risk assessment conference (MARAC) meets monthly. It is well attended by partner agencies. Actions are clearly recorded and reporting back on actions taken is timely. Lambeth has a low repeat victimisation rate of 21%, with a target of 20%, indicating that action taken is effective in reducing risk. However, CAADA analysis of Lambeth's self-assessment identifies potential under-reporting overall. Data submitted to CAADA between April 2013 and March 2014 show that the Lambeth MARAC discussed 387 cases; this is 77% of the projected volume of 500 high risk victims per year and a 2% decrease since the 2013 self-assessment.

64. Multi-agency public protection arrangements (MAPPA) are robust and thresholds are in line with other authorities in Inner London.

65. When children are identified as the victim, or are at high risk of child sexual exploitation, complex strategy meetings are held, chaired by a sexual exploitation specialist. These meetings are well attended by relevant agencies. Detailed information is shared to form an holistic view of the known and suspected risks to the young person, and is used to plan action to reduce the risk. The process is supported by regular review at the multi-agency sexual exploitation (MASE) panel.

66. Potential links between children at risk of sexual exploitation and children who go missing from home, care or education are well understood at a strategic level. Recent multi-agency policies and procedures have been strengthened, based on learning from best practice. For example, recently the police have agreed that all police missing persons' reports and safe and well checks will be routinely shared with the local authority children's services. Children not already receiving a social work service are risk assessed on a case by case basis, and all children who meet the threshold of two missing episodes in a 90-day period are referred for a child and family assessment of need. Notifications of missing episodes on open cases are passed to the allocated worker to complete a return interview within 72 hours of their return.

67. However, practice in relation to these procedures is far too variable, and some workers and managers expressed uncertainty about how to record missing episodes. In the majority of cases, return home interviews are not carried out systematically for children and young people who go missing from home and care following each missing episode, and there is insufficient analysis of individual triggers and patterns to reduce risk. Inconsistency in recording of missing episodes makes it difficult for the local authority to collate and analyse the prevalence. Recent introduction of a child sexual exploitation risk assessment tool within children's services, for use with all children over age 10, has resulted in an increase in referrals to the MASE panel. However, the lack of timely return interviews in cases seen indicates that workers' understanding of the increased vulnerability to sexual exploitation of children who go missing is

underdeveloped. The local authority has recently commissioned a voluntary sector organisation to undertake return interviews to improve quality and timeliness.

68. At the time of inspection, 34 children were missing from education in Lambeth. The system to monitor children missing from education is well established and includes clearly defined criteria for: children home educated; school aged mothers; young people with health needs who require specific arrangements; young people with poor attendance or persistent absences; and young people in young offender institutions or being supported by the youth offending service. The multi-disciplinary Vulnerable Pupil Monitoring Group works effectively with the most complex cases to resolve issues and ensure that young people are provided with suitable educational alternatives.

69. Alternative education provision is provided by a pupil referral unit, and is supported by a robust service level agreement. Wherever possible, young people are supported back into mainstream provision or have a managed move or transfer. Education welfare officers work alongside their police colleagues in monthly truancy sweeps, particularly targeting local addresses where young people are known to congregate. Staff carefully monitor all those pupils who are known to be home educated and currently they are supporting 62 pupils. Regular home visits are underpinned by additional advice and guidance to parents, along with access to educational resources. At least half of home educated pupils are waiting for admission to particular schools of their choice.

70. Homeless 16- and 17-year-olds receive initial screening from the local authority to determine their levels of vulnerability, and those who need it receive continued support as looked after children. In some cases family mediation is offered to achieve reconciliation. In a few cases seen by inspectors, children were not assessed as vulnerable, did not receive a timely service and their problems increased as a result.

71. Robust multi-agency intervention and tracking activity is undertaken with high risk gang members. The majority worked with are aged 18 or older, although currently 20 under-18 year-olds are receiving 1:1 support and intervention. Data on the effectiveness of intervention with these young people are not collated from overall figures. Current figures are positive, showing that 82 out of 133 former gang members are no longer involved in the gangs. Of these, 23 are in custody, leaving 59 who have ceased measurable activity for other reasons.

72. For children who do not meet this high threshold, individual work is undertaken through targeted provision offered by a range of commissioned services. Some innovative work with girls and young women as part of the 'Expect Respect' project has been successful in increasing the number of vulnerable young women engaging with the project and increasing opportunities for preventative work with this often hard to reach group.

73. There is a gap in provision for young people whose level of involvement with gang activity requires a more intensive response than can be provided by targeted services alone, but who do not yet meet the threshold of high risk. Junior intervention meetings have recently been introduced with a view to bridging this gap, but it is too recent to measure their effectiveness.

74. Where allegations are made against professionals, the local authority designated officer (LADO) ensures that appropriate and proportionate action is taken. This has included challenge to agencies where they have been reluctant to engage in robust safeguarding practice. Although systems for tracking and recording of cases need refining in order to provide good quality performance management, recording by the LADO is sufficient to detail actions taken and identify and address any issues. Complex strategy meetings are appropriately recorded, and generally well attended by relevant agencies.

75. At the time of inspection, 20 children living in private fostering arrangements were known to the local authority children's services. Children are visited by a social worker within the appropriate timescales, their needs are suitably assessed and reviewed. They benefit from regular scrutiny by the private fostering panel. Notifications are low and are estimated by the local authority to be significantly under-reported, despite good levels of awareness-raising activity undertaken by the small, dedicated private fostering team.

76. The local authority has a diverse workforce which reflects the rich ethnic and cultural mix of the local population. However, responses to children's needs arising out of diversity are inconsistent. Inspectors saw examples of careful consideration of diversity needs informed by a sophisticated understanding of complex issues, but also saw a small number of cases where workers struggled to meet some most basic needs, such as providing interpreters or translations of documents for families who required them in order to be able to understand and engage in what was happening to them and their children.

77. Lambeth has been identified as a priority area for the 'Prevent' agenda overseen by the Safer Lambeth Executive. The local authority and partners have been proactive in their engagement. Training has been provided within schools and to other frontline workers, and the prevention and identification of radicalisation are built into strategic plans around child sexual exploitation and gang activity and as part of a wider safeguarding agenda.

Key judgement	Judgement grade
The experiences and progress of children looked after and achieving permanence	Inadequate

Summary

Looked after children and young people receive an inadequate service from children's social care services.

Not all looked after children at risk of sexual exploitation are recognised. Return home interviews are not being routinely undertaken when a looked after child returns after a missing episode, indicating a lack of concern about their behaviour and exposure to potential risks.

Permanency planning is not prioritised; this results in children living in temporary placements for too long and being uncertain about their future.

The use of the Public Law Outline (PLO) process is not well established, plans and timescales are not clearly stated, and risks to children and children's experiences are not given sufficient focus. Social work reports for court are not of a consistently high standard and are not robustly overseen by managers.

Too many changes of social worker for some looked after children and care leavers have resulted in lack of progress and continuity of care planning, and in poor engagement and relationship building with the young people and their carers. Direct work with children, such as life story work, is not routinely or consistently undertaken by social workers or carers.

Care plans vary in quality and some are not consistently up to date, comprehensive or systematically implemented. Case recording is not sufficiently focused on addressing the care needs of the child or young person. Information on the system is hard to find and reasons for decisions are not clearly explained. Independent reviewing officers are not effectively escalating concerns where standards are not met.

Initial health assessments as children become looked after are not routinely completed in a timely manner, so health needs are not known at an early stage.

Children in Lambeth are waiting too long to be adopted. The local authority has not put in place a sufficiently robust plan to improve the quality of practice or address the delays that children experience. The recruitment and assessment of prospective adopters are not timely, which delays adoptions and may deter some applicants.

Not enough foster carers are being recruited to meet the varied needs of looked after children in the area.

Pathway plans are not sufficiently up to date or outcome focused. Not enough care

leavers are in education, employment and training.

78. Safeguarding concerns for children missing from care are not effectively assessed. Independent return interviews are not being routinely undertaken within 72 hours of when a looked after child returns after being missing. Further, children are not being routinely seen or contacted by their social worker following a period of being missing. As a result, potential risk to the young person and others when young people go missing is not being consistently assessed or addressed by social workers.

79. In a minority of cases seen by inspectors, looked after children who had been missing from care received a timely return interview. The quality of those interviews was not robust. In other cases, although some of the young people had been seen at a later date in scheduled visits, few of them were spoken to about each missing episode. This included a young person who was at significant risk, whom the local authority subsequently identified should have been referred to the MASE panel, and for whom a strategy discussion was indicated to consider escalation of risk. This lack of rigour results in risk remaining unaddressed and may give a message to young people that their going missing is not considered important, or even that workers do not care what happens to them.

80. A child sexual exploitation risk matrix has very recently been completed on all looked after children aged 10 and above, to enable risks to be identified and taken into account when planning for looked after children.

81. No cases were seen where children who were looked after did not meet the appropriate threshold. However, a small number of cases were inappropriately closed following assessment, without further support being provided. These children were subsequently accommodated within two months of case closure.

82. The decision-making process for children becoming looked after is not robustly recorded. All requests for accommodation are authorised by a senior manager when a placement is requested from the Access to Resources Team (ART). However, these documents, which evidence a key decision-making point, were seldom visible on the local authority electronic case recording system.

83. In most cases seen, decisions to return children home from care were appropriate, with children returning home with a plan of support in place. However, in a small number of cases, the local authority had not worked proactively with children subject to care orders who wanted to live with their parents, either to enable a return home or to explain why this could not happen. For example, in one case, arrangements to assess a father as a carer for the young person had not been completed, despite being initiated in 2013.

84. Permanency planning is not sufficiently prioritised, resulting in some children living in temporary placements for too long. Permanency planning processes

are in place but need to be embedded. Contingencies are not explored nor are parallel plans put in place for these children, who urgently need permanence in their lives. The placement panel is currently focusing its attention on reviewing high cost placements, but does not track children's progress.

85. The average case duration for care proceedings in Lambeth for 2014–15, quarter 3, as agreed by the South London Care Proceedings Project and excluding two longstanding 'legacy' cases, is 35 weeks. This is significantly above the national target of 26 weeks. It has reduced year on year for the last three years, and is roughly in line with the average for all applications in the Central Family Court. Senior managers are working with the South London Care Proceedings Project to improve timescales and to increase effectiveness within court proceedings.

86. The use of PLO processes is not well-embedded. Cafcass reports that cases are still arriving in court that are inconsistent in quality and have information missing. Cafcass also reports cases involving neglect of young children coming to court after the child has been accommodated voluntarily for some time. This was confirmed in cases seen by inspectors. Minutes from the pre-proceedings monitoring panel do not demonstrate robust management of the work being undertaken. Plans and timescales are not clearly stated and risks to children and children's experiences are not the primary focus.

87. More recent social work reports seen by inspectors were of a better standard. However, the judiciary informed inspectors that Lambeth's court work is frequently disrupted by changes of social worker, and that workers often lack the skill, experience and confidence required at court to represent children's best interests well.

88. The local authority has had an increase in children leaving care through special guardianship orders (SGOs). The assessment and support of SGO carers has recently been moved from the adoption team to the fostering team, to align with the connected persons' process. Seventeen children are currently being assessed for an SGO.

89. Case recording is not sufficiently focused on the care needs of the children. In a small number of cases where children were settled in their placements, visiting by social workers was taking place every three months, but the management decision authorising this was not evident on the case file. In most cases seen, social workers were visiting children in their placements in accordance with statutory guidance, were seeing them alone and were considering and recording their views.

90. Frequent changes of social worker featured in the vast majority of cases seen; this negatively impacted on the strength of the relationship that the young person had with their social worker and on the continuity of care planning.

91. In the majority of cases seen by inspectors, there was evidence of regular supervision having taken place. However, systematic recording of key decision making is not being clearly noted on case files. Looked after children cases are also allocated within the Family Support and Child Protection Teams, where caseloads are slightly higher and deficits in recording are more marked.

92. Life story work is not being routinely undertaken by social workers, and few case files contained life story work undertaken by carers. Little if any evidence was seen of direct work being undertaken with looked after children, despite social workers in the children looked after teams having manageable caseloads of between eight and 13 young people.

93. Contact arrangements with families and carers are dealt with effectively. Inspectors saw examples where child-friendly arrangements have been established.

94. Advocacy services are in place to support looked after children who require additional support to resolve issues in relation to their care planning. The internal advocate worked with 14 looked after children in the first quarter of this year. A commissioned service worked with 27 looked after children between October and December 2014, with 10 cases remaining open at the end of the year and 45 issues resolved. Eleven independent visitors are currently in place and there is no waiting list for this service.

95. The vast majority of looked after children attend good or better schools. In the very small minority of cases where this is not the case, virtual school staff monitor pupil progress extremely carefully and work with the school to ensure that young people make the progress expected of them. Virtual school teaching and learning consultants carefully monitor and track the progress of the current cohort of 292 school-aged children through their Personal Education Plans (PEPs), making effective interventions when required.

96. School attendance is thoroughly monitored, and for 2012–13 was slightly above national averages. Virtual school staff reward children for good attendance by awarding certificates where attendance is above 98%. Overall attendance for looked after children is good at 96%. From September 2014 to date, 19 children have had fixed term exclusions. In each case, the child was offered support or alternative provision and carefully monitored until they could return to full time education. Wherever possible, staff work towards managed moves rather than exclusions. No looked after child has been permanently excluded in the last two years.

97. While the quality of PEPs does vary, most plans seen by inspectors were thoroughly prepared and fit for purpose. Virtual school staff carefully monitor the quality of PEPs and, if necessary, support social workers and designated school staff to ensure that these plans effectively capture young people's progress and set realistic educational targets to help them improve. Most plans contain appropriate, and in some cases, ambitious targets to ensure that young

people reach their potential. The use of the pupil premium is carefully monitored by virtual school staff, and it follows the pupil. It is used to support young people in a variety of ways, including one-to-one support, additional learning resources, out of school activities, specialist subject support and therapeutic interventions where necessary.

98. Looked after children and young people in Lambeth make expected levels of progress across all year groups, broadly in line with national rates. At Key Stage 2, children showed improvements in reading, which were supported by on-line learning opportunities and the letterbox library.

99. While looked after children do not yet do as well as their peers in Lambeth at Key Stage 4, the attainment gap is closing. For example, the proportion achieving five GCSE A*- Cs including English and mathematics has improved from 23% to 36% in 2013–14. This compares very favourably to the national rate of 16%, but it remains lower than the Lambeth average of 57% for all pupils.

100. Schools both inside and outside the borough are well informed about risks to young people, including cyber-bullying, gang violence and sexual exploitation. Instances of bullying are dealt with swiftly and appropriately, with multi-agency intervention if necessary, for example from the community police.

101. Poor performance by the local authority in initiating health assessments resulted in fewer than half of the children entering the care system between November 2014 and January 2015 receiving a health assessment within 20 working days. While this has been an issue for some time, managers could not explain why assessments were not undertaken to timescales or how the situation could be improved.

102. Once the looked after children health team is informed of a child or young person becoming looked after, proactive services are provided, with a contractual agreement to work up to 20 miles outside the local authority. During 2013–14, 95% of Lambeth's looked after children had had an annual health assessment, 88% were up to date with their immunisations and 92% of Lambeth's looked after children had a dental check. These figures are roughly in line with or slightly above national averages.

103. Most looked after children reviews are being completed within prescribed timescales. However, some social work reports for these meetings are not received by the independent reviewing officers (IROs) in a timely way to enable them to be properly prepared. The majority of looked after young people do attend their reviews, but ways of maximising their engagement and participation are underdeveloped. Foster carers report that young people are not being supported to complete their wishes and feelings booklets prior to reviews.

104. Social workers were able to demonstrate to inspectors that actions to follow through review decisions were taking place. However, this was not systematic and did not demonstrate that all aspects of the care plan were being implemented. Some care plans seen by inspectors were not comprehensive and needed to be updated. In two cases seen, the local authority's own staff could not find the care plan on the case file. Some care plans seen by inspectors were of a higher standard but this was not consistent.

105. IROs are not escalating concerns, preferring to try to resolve matters through discussions with the teams. In too many cases seen by inspectors, this resulted in delay in ensuring permanent arrangements for the young people. A new escalation policy has just been approved, but it is too early for it to have an impact.

106. At the time of inspection, three looked after children were in custody and four were subject to court orders for offending. The local authority reports that these numbers have been coming down year-on-year because of good partnership working by the youth offending services to produce credible bail support packages. Remand cases seen by inspectors were of a good standard, with reviews taking place as required and young people being visited every two weeks by their social workers, who are undertaking purposeful work aimed at reducing re-offending.

107. The standard of recording in looked after children case files is too variable. During the inspection, local authority staff had difficulty in locating documents on case files, and the case record does not reflect the journey of the child. Where there are changes of social worker, this makes it difficult for new workers to understand what work has been undertaken and to continue with the care plan for the child. It also undermines the effectiveness of management oversight. Case records do not provide children and young people with an explanation of why significant decisions in their lives have been made and what influence they and their families had over events.

108. Most looked after children live outside the borough, but within 20 miles of home. At 31 March 2014, only 110 children (21%) were placed within the local authority boundary, and 420 outside. However, 310 of the 420 placed outside were placed within 20 miles of their home. The local authority does not collate information on the children who are placed over 20 miles away home to assure itself that those young people are not disadvantaged and are able to access the full range of services to meet their needs. Young people and carers living both near and far from the authority similarly reported that face-to-face contact with social workers was good but that they experienced difficulties contacting staff by telephone, and also that they did not routinely receive information that they needed, such as information on their entitlements.

109. Local authority foster placements overall are of good quality. Inspectors met with 10 foster carers, who ranged in experience from six months to 21 years and who had a range of ages of children in placement. The foster carers were

generally very positive about the service they received from their supervising social workers.

110. The fostering service has not been able to recruit and retain a sufficient number of foster carers to provide local high quality placements capable of meeting the wide range of children's needs. Instability in staffing in the fostering team and uncertainty about whether the local authority intended to outsource this service have resulted in a lack of progress and development. The team has focused on trying to retain foster carers rather than recruiting more carers. The number of foster carers in the service has increased marginally in recent years. In 2012 there were 93 foster carers and 25 connected people. At the time of inspection there were 107 foster carers and 32 connected people.

111. The shortage of foster carers means that the local authority is reliant on a high number of agency placements to meet the needs of children and young people. Of 480 young people, 287 are placed in agency placements, 246 with independent foster carers and 41 in residential settings. The local authority is currently reviewing the significant cost and staff resource demands of visiting these placements and the quality of their provision.

112. Placement stability is similar to England averages. Short-term placement stability, based on three or more placements during the year, was 12% across the three-year average. This was similar to the England average of 11%. The long-term placement stability average was 70%, which was slightly above the England average of 67%.

113. The views of children and young people are strongly represented through the Children in Care Council. This is formed by a group of 25 young people aged 18 to 23 years, called 'Visions of Success', and a group of 30 children aged 12 years and under, called 'Young Visions'. The children regularly have access to and are consulted by senior managers. They also interview potential employees and provide training for new staff. In the past year they have been instrumental in developing Contact Cards, Entry to Care Packs and the Be Safe booklet, aimed at alerting young people to the risks of cyber-bullying. The young people are aware that they are a relatively small proportion of Lambeth's looked after and care leaver populations. They routinely use mailshots and telephone contact with the wider looked after children population to provide information and to seek to recruit new members.

The graded judgement for adoption performance is that it is inadequate

114. Too many children in Lambeth wait too long to be adopted. The adoption scorecard for 2011 to 2014 shows that children in Lambeth waited an average of 1,081 days between entering care and being placed for adoption. This is 534 days longer than the national target, 453 days longer than the England average, and 347 days longer than statistical neighbours.

115. Despite some improvement in 2014, the average time that children with a placement order waited to be matched during 2011 to 2014 was 407 days. This is 255 days longer than the national target, 190 days longer than the England average, and 165 days longer than statistical neighbours.

116. Data from 2011 to 2014 also show that too many children in Lambeth wait more than 18 months from entering care to moving in with adopters. An average of 29% of children looked after in Lambeth were placed for adoption within 18 months of coming into care during this period compared with an average of 51% of children in England, and 41% for statistical neighbours.

117. Children are not considered for adoption at an early enough stage in Lambeth. A diagnostic assessment of adoption services in March 2014 identified that a high proportion of children being placed for adoption entered care at a young age (68% were under three months). However, unlike other local authorities, these children were, on average, not placed for adoption any more quickly than older children. This is significant as it indicates systemic deficits in early permanence planning rather than delay being caused solely by the complexity of some children's needs.

118. Following this diagnostic assessment, some action has been taken to improve practice, but it is too early to demonstrate any impact. There was little evidence during this inspection of a coherent strategy or policy that had improved practice or had any direct impact on the delay that children experience. For example, unless the court requests a statement about family finding during care proceedings, referrals continue to be made to the adoption team only after placement orders have been made, creating unnecessary delay for the vast majority of children. All of the cases seen during inspection demonstrated delay in family finding, in addition to permanence decisions not being made in a timely way, and paperwork often taking too long to complete and present to the adoption panel.

119. Although identified as an issue during the diagnostic assessment, the quality of the data available in respect of adoption and the ability of the local authority to analyse it effectively continue to hamper the understanding and development of the service. The local authority was unable to provide child-level data during

the inspection that was of a standard that would enable any analysis of the current cohort by inspectors.

120. The adoption scorecard for 2011 to 2014 shows that 7% of children left care through adoption, which is lower than the England average at 14% and statistical neighbours at 10%. Of children who left care who were over the age of five, 4% (25) were placed for adoption, which is just below the England average of 5%.

121. Of children from minority ethnic groups who left care in Lambeth between 2011 and 2014, 6% (40 children) were placed for adoption, which is below the England average of 8% and statistical neighbours at 7%. This is a significant under-representation in comparison with the local population, as children from minority ethnic groups account for 64% of all children living in the area, and 79% of looked after children (March 2014). Lambeth has high numbers of Black children, particularly boys, and children of dual heritage to place for adoption, for whom there is less choice of placements. This has an effect upon adoption performance and has not been fully analysed or addressed by the local authority.

122. The local authority does not have sufficient adopters available to meet the needs of children who require placements. Despite an increase in the number of adopters during 2013–2014, challenges persist in recruiting sufficient adopters. At the time of inspection, only seven sets of adopters were available to consider placements. All of these were white British.

123. The local authority takes part in regional arrangements to support family finding for children. It is part of the South London Adoption Consortium, recently expanded to include North London. Staff attend regular meetings and share information to try to identify adopters for children. The authority routinely uses 'Be My Parent' to promote profiles of children, and refers children to the Adoption Register. Lambeth adopters attended a BAAF-facilitated adoption activity day in August 2014, but the local authority did not feature any of its children. Recruitment activity during 2014–2015 has been focused on partnership with the voluntary sector, to raise awareness and recruit adopters from the faith communities. This work began in July 2014 but has not yet resulted in any adopters being assessed or approved. The local authority has not developed other strategies aimed at reducing delay for children, such as Fostering to Adopt.

124. At the time of inspection, 60 children had an adoption plan, of whom 22 were placed for adoption, leaving 38 children not yet placed. This cohort is reported to include 13 children who are matched to carers and three children waiting who have no link or match. The remaining children have had a change of plan. The proportion of children for whom the permanence decision has moved away from adoption is 13%, which is only 1% above the England average, but this is likely to be increased by the proposed number of revocations of plans for adoption.

125. The local authority's adoption recruitment process is in line with government requirements, with all the required checks being undertaken. In some cases additional support is given to adopters to enable them to address issues, develop and go on to be approved. The local authority supports and promotes well the approval of same gender carers for children who require adoption.

126. Timeliness of the recruitment process remains poor. Only one adoptive family completed the process within six months. Following the adoption diagnostic assessment in March 2014, some roles in the adoption team were restructured. Clear guidance about processes and timescales has been provided to staff, and data and information are being better used to monitor performance. This is beginning to have a positive effect on improving the timescale for stage two of the process.

127. The quality of Prospective Adopter's Reports (PARs) is variable, with most seen by inspectors as requiring improvement and one seen being good. Managers recognise the need to improve consistency in the quality of this work. Three adopters spoken to were positive about their experience of assessment and of the panel. They thought that the report (PAR) was an accurate reflection of the work they had done. All felt that adoption support was considered according to the needs of the child and was realistic.

128. Most children's files seen recorded that the Agency Decision Maker (ADM) had agreed the plan of adoption. However, these were one line statements and offered no evidence of the rationale for decisions undertaken or the key arguments considered. This is required by Adoption Statutory Guidance 2013. As a result, the rationale to understand how decisions were made is not available for workers, the adoption panel, adopted young people or adults who may later read their files. Where the ADM had considered children being matched for adoption, these records were also brief and did not adequately reflect full consideration of the individual children.

129. Processes for matching children with adopters are established and are consistently followed. All children are discussed at matching meetings, presented to panel, and meetings take place to plan introductions. Adoption support plans are in place for children at the point of adoption. Support is considered and is provided to adopters, including financial assistance in many cases seen.

130. Post-adoption staff from the adoption team visit all adoptive families at the point of the adoption taking place, to explain the services available. They support and facilitate direct and indirect contact for children placed for adoption and those in special guardianship placements. The post-adoption worker has completed three assessments during 2014–15 and is currently working with 10 families. Some work seen demonstrated child-centred and effective support being provided. However, in most cases this was not based on an assessment of need or an agreed plan. Additional counselling services are provided through the independent post-adoption contact service. Adopted children who require

psychological support can experience delays in accessing child and adolescent mental health services (CAMHS), as they are not identified as a priority group.

131. Life history work is not routinely being undertaken in a timely and effective way. As a result, life story books and later life letters were not available for children placed for adoption in some cases seen. This results in some children living in adoptive placements where their adopters do not have material available to enable them to support their children to understand their life story.

132. The Adoption Panel has an experienced and knowledgeable chair. Members have diverse backgrounds and the majority are independent. Medical and legal advice is readily available to them, and panel minutes demonstrate careful consideration of approvals of adopters and matching of children. Quality assurance of the reports presented to the panel is not consistently effective, although feedback about areas requiring improvement is regularly given to social workers and managers.

133. The Chair provides regular reports to the local authority about the adoption service and practice issues. The most recent report, in November 2014, acknowledges some good examples of work, but also provides considerable detail and clarity about areas that require further improvement. It makes clear that these issues have been raised in previous reports and have not been addressed by the local authority. A recent action plan has now been put in place, but it is too early to demonstrate any impact.

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

134. Care leavers are helped to understand how their life choices will affect their safety and well-being, but pathway plans seen do not focus sufficiently on reducing risk. All care leavers' files seen had a sexual exploitation risk assessment completed. Return interviews are conducted by the care leavers' social workers following a missing incident, although not all case files had a record of them. In a small number of cases seen, care leavers aged under 18 years who had been missing did not receive a return interview from their social worker and were not subsequently spoken to about the missing episode.

135. The quality of pathway plans is too variable. The educational component of pathway plans does not focus sufficiently on educational next steps or on employment. The voice of the young person is not evident and plans are not sufficiently specific or measurable. Few plans make any meaningful comment on the culture and identity of care leavers. The local authority's monthly data on performance on pathway plans show that 66% were overdue in February 2015. While still too high, this is an improvement from October 2014, when 72% were overdue. As a result of closer managerial oversight there has been a

slightly improving trend in timeliness over several months. Young people told inspectors that they do not find their pathway plans to be helpful. The local authority is currently reviewing the format of these plans, with help from young people.

136. Care leavers have good access to services that support their health needs. The leaving care service is based within a health setting, which enables care leavers to access health care services immediately, if required. The looked after children's nurse is proactive and flexible in her approach to care leavers to ensure that they know about and can access health advice and treatment. The nurse will visit care leavers living outside Lambeth if required. The looked after children medical team also provides weekend and evening clinics and will undertake home visits, for example with a member of the sexual health team.

137. All young people spoken to by inspectors said that they were registered with a general practitioner and a dentist. Care leavers have access to counselling through a range of services or though their GP. However, at the time of inspection there was an eight month delay to access CAMHS for assessment.

138. The process for ensuring that care leavers have access to their health histories is not sufficiently clear. The looked after children nurse reports that care leavers have health passports that enable them to access important information about their health histories when seeking medical treatment. However, not all care leavers spoken to said that they had received their health histories.

139. Lambeth care leavers are able to access a wide range of support provided by the care leaving service. For example, the What Happens Next programme offers pre-tenancy training for young people looked after aged 16 and over. Care leavers who have fallen into rent arrears can access a two-day accredited training workshop on tenancy sustainment and money management. Successful completion of the course provides access to additional support. Feedback from participants has been positive, but the longer term impact of this course has not been evaluated.

140. Care leavers are also helped to develop the skills to live independently through workshops and training provided by their carers, and to manage safe relationships through the What Happens Next programme. The leaving care grant is set at the national recommended level of £2,000. The local authority provides helpful written materials and a Lambeth care leavers' website contains additional information and practical guidance.

141. The virtual school has very recently appointed a teaching and learning consultant to take responsibility for monitoring the educational progress and destinations of care leavers, but at the time of inspection the educational support to care leavers was not well co-ordinated or sufficiently monitored.

142. The local authority does not have accurate information on the number of care leavers not in education, training or employment (NEET). Individual educational

support is available to work with care leavers who are NEET. This has not resulted in increased numbers of care leavers gaining apprenticeships or employment. Recently, contact has been made with local employers to explore work experience opportunities, although it is too early to evaluate its impact. Staff are not sufficiently proactive in developing local partnerships, for example with further education colleges, to support young people with significant barriers to learning or who are not yet ready to undertake work.

143. The 'Steps to Success' (S2S) programme supports care leavers into meaningful paid work experience within the local authority, and has supported 80 care leavers during the last five years. Nine care leavers went on to secure paid employment in 2014. Wider opportunities outside the local authority for care leavers to engage in work-based learning or work experience are under-developed, although two care leavers have recently secured internships in the financial sector.

144. Currently 35 care leavers are at university, and the local authority provides a good package of support, including accommodation during the holidays if required. The number is similar to levels in statistical neighbours for the local authority.

145. The local authority celebrates the achievements of care leavers in an annual 'Reach for the Stars' award event. This is highly valued by those care leavers who receive awards, who spoke with pride about their experiences. The authority looks to celebrate a wide range of achievements. However, not all care leavers are nominated for awards and those who are not nominated are not invited to such ceremonies and are further marginalised.

146. The local authority reports that 87% of care leavers live in suitable accommodation. The care leaving service remains actively involved with the remaining 13%. Most young people who spoke to inspectors said that they were given alternative options when they felt the housing offer did not meet their needs, or if they felt unsafe in their tenancies. Most care leavers seen by inspectors reported that they felt safe where they lived.

147. Care leavers are encouraged to remain in care until they are 18, and in 2014 77% of looked after young people did so. 'Staying Put' arrangements are increasingly being considered for young people leaving care, to enable them to remain with their carers. Seven young people benefit from 'Staying Put' arrangements with Lambeth foster carers and 13 care leavers with agency foster carers. The care leavers' service ensures that the young people staying put also secure housing nomination rights. Looked after children spoken to by inspectors were aware of their entitlement to stay put. The care leavers' service has close working arrangements with the local authority housing department to ensure that all care leavers are offered either a tenancy from the council housing stock or from another social housing provider. A private tenancy is only considered in exceptional circumstances.

148. At the time of inspection, the local authority reported that no care leavers were living in bed and breakfast accommodation. However, some data provided for the inspection indicated that a few young people were or had recently been in bed and breakfast accommodation, so the actual position was unclear.

149. Care leavers who were in custody at the time of inspection were supported and regularly visited by their social workers. One care leaver was supported into a semi-independent unit on discharge and is undertaking an apprenticeship in retail. The Legal Aid, Sentencing and Punishment of Offenders team provides an effective bridge for young care leavers in custody.

150. The care leavers' service reports that it is currently in touch with all but four care leavers. Staff make efforts to trace all young people and encourage them to resume contact using texts and telephone calls.

151. Not all care leavers said that they are provided with information about their entitlements, but most said that they have an awareness of the complaints process or knew who to ask if they were unhappy with the service being provided.

152. The use of performance information is underdeveloped in the care leavers' service, and this is not assisted by performance data, which is not fully accurate. Managers do not have a strong grip on the quality of individual work or the quality of the care leavers' experiences of the services provided. They do not routinely undertake case audits of the work within the team.

Key judgement	Judgement grade
Leadership, management and governance	Inadequate

Summary

Progress has not been sustained since Ofsted judged the local authority as outstanding for both safeguarding and services to looked after children in 2012. Most of the areas of strength identified then have deteriorated significantly. The absence of an effective performance management and monitoring system means that local authority senior managers and elected members do not have sufficient knowledge and understanding of social work practice. Consequently, services for looked after children and those waiting for adoption are inadequate, and services for children needing help and protection and for care leavers require improvement.

The local authority self-assessment dated December 2014 and completed in anticipation of this inspection is over-optimistic. Most services are self-assessed as good. Shortfalls known to leaders and senior managers were not accurately or effectively analysed. Supervision by managers is not robust and does not provide leaders with an accurate understanding of the quality of practice.

The Corporate Parenting Panel does not effectively scrutinise outcomes for all looked after children and care leavers.

Staff do not systematically record all activity on the local authority children's electronic case system. As a result, managers cannot be assured that data and information about children and young people are accurate.

Risks to children and young people who go missing are not assessed, as return interviews do not take place in line with regulation.

The local authority has experienced difficulties in recruiting and retaining experienced social workers and managers. This leads to children and their families experiencing frequent changes in social worker, and negatively affects the consistency and quality of practice. All levels in the organisation rely too much on locum staff.

Leadership has been inconsistent and fragmented. Recent action by the Director of Children's Services and senior managers is beginning to make a positive difference, but it is too soon to evaluate impact in most areas of service.

Partnerships with other statutory and voluntary organisations are strong, although these have been strained by significant changes of local authority managers and staff in recent years.

153. The local authority self-assessment dated December 2014 and completed in anticipation of this inspection is over-optimistic. Most services are self-assessed as good. Shortfalls known to senior managers were not accurately or effectively analysed, despite being identified in late 2014. These included significant deficits in practice: drift in progressing work for many children, lack of compliance with statutory visits to vulnerable children within prescribed timescales, poor management oversight of work, and inadequate performance and quality assurance processes.

154. Corrective action has been taken by the Director of Children's Services to drive improvement across most service areas, particularly over the past six months. In some areas this has had a positive impact, for example in the development of the multi-agency safeguarding hub (MASH) and the First Response Teams (FRT). However, inspectors found that all services for vulnerable children and their families either require improvement or are inadequate. Senior leaders, managers and elected members do not therefore have a realistic understanding of the quality of frontline practice, management oversight and whether children and their families are effectively helped, cared for and protected.

155. Performance management is ineffective within the local authority children's services and is not underpinned by accurate performance information. Throughout the inspection, the authority struggled to provide timely or accurate data and management information. Operational managers did not demonstrate a clear or accurate understanding of the effectiveness of the services that they manage. A monthly performance digest is disseminated to managers. However, this often contains inaccurate or poor quality information and important information is unavailable or unreliable. For example, the analysis of children missing from home and care is not accurate. It is therefore difficult for managers to monitor and measure improvement for children and young people. A quality assurance framework linked to learning and development has recently been launched to strengthen case auditing and management oversight, but it is too soon to evaluate its impact.

156. Overall, management oversight of practice is inconsistent and managers at all levels do not routinely undertake audits of work for which they are directly responsible. The local authority commissioned external audits of children's services in October 2014 and of supervision in January 2015. The Health Visiting Service and the School Nursing Services were reviewed in 2013. These provided an independent analysis of deficiencies in practice across the teams. They rightly found a range of issues, such as: only a small number of assessments were child centred; analysis in most instances was lacking and tended to be descriptive; some children appeared not to have had an updated assessment for some years. An action plan is in now place that prioritises these areas for improvement, many of which persist.

157. Supervision of social workers and managers does not consistently take place in accordance with the local authority's policy. The audit of supervision in January 2015 identified variability in practice. This inconsistency was still evident in

supervision files seen or sought by inspectors. For example, managers' supervision files were not available in the MASH and FRT teams. In the looked after children and care leavers' services the quality of supervision is mostly poor. There is a lack of evidence of any management oversight or supervision taking place within the adoption service. As a result, the quality and timeliness of the service to children are not being appropriately quality assured or managed, resulting in unacceptable delay for these children. A revised supervision policy and tool have been introduced, but it is too early to see their impact.

158. Children who go missing from home and care are rightly recognised as a priority for the local authority and its partners. However, not all children who have gone missing received a return interview within 72 hours of their return. Inspectors sampled cases of children missing from care where social workers contacted young people by phone and text, but there was no evidence that the young people had been offered or had had a return interview. Inspectors saw records of social workers visiting children about two weeks following the missing episodes, but there was no recorded evidence or risk assessments of why young people were missing from care. In February 2015, the local authority commissioned a voluntary sector organisation to offer return interviews, to enable young people to speak to an independent person.

159. A spread sheet has been in place since December 2014 to record missing episodes; this is tracked and cross referenced with children at risk of sexual exploitation. A critical log of serious incidents is reported to the DCS, senior managers and the Lead Member. However, performance information is unreliable as staff do not systematically record activity on the electronic case system. Trends are not understood, assessed or aggregated by senior managers. Managers who spoke to inspectors were not able to provide assurance that the data about children missing from care are accurate. Manual systems continue to be employed to assist operational managers in managing services.

160. The arrangements to track and monitor children at risk of child sexual exploitation have been reviewed and strengthened in the past six months. Complex strategy meetings for those young people identified as being at high risk are effectively chaired by a sexual exploitation specialist worker based in the MASH. Almost all cases are appropriately escalated to the MASE and multi-agency action plans devised to reduce risk and disrupt perpetrators. The use of a risk assessment tool is being rolled out and is beginning to identify more young people at risk. The Local Safeguarding Children Board's exploitation sub-group, established in January 2015, is beginning to cross reference young people who go missing, who are at risk of sexual exploitation, and those at risk of gang-related issues.

161. The looked after children Commissioning and Sufficiency Strategy for 2012–14, and the draft strategy for 2015, do not offer an effective analysis of the placement needs of looked after children, nor a plan of how the local authority

will meet this need. The draft strategy lacks critical analysis; for example, it states that the fostering service has had 'steady and significant growth', although overall numbers of carers have only increased from 93 in 2012 to 107 in 2015. This is partially due to a decision to outsource aspects of the fostering service, which meant that expansion of the service would be put on hold. A decision to keep the service 'in house' was made in November 2014 but, while the local authority has identified that the service needs to grow and develop, a strategic plan has not been put into place to deliver this. Consequently, the authority is reliant on a high number of high-cost agency placements to meet the needs of children and young people.

162. Of 480 young people in care, 287 are placed in agency placements. Of these, 246 are in independent fostering agency (IFA) placements and 41 in residential care. About half of these young people live in placements provided by IFAs that are not part of the local authority's approved framework arrangements. These are not subject to the enhanced contractual quality assurance processes that are in place for preferred providers. During the inspection, the authority was unable to provide a current analysis of the needs of the children and young people who are placed more than 20 miles from home. The placement panel, which was reconfigured in February 2015, is reviewing all of these placements to ensure that the care provided is of a consistently good quality.

163. The new lead member, appointed in November 2014, meets regularly with children's services directors, staff and partner agencies, and demonstrates an understanding of key issues affecting children's services. These include poor performance issues such as in adoption, the number and costs of IFA placements and the failure to offer, record and analyse return interviews with missing children. The lead member reads all the MASE minutes, the Director's critical log and data on missing episode. However, it is too soon to see the impact of this oversight. The Chair of Overview and Scrutiny was not aware of these key issues affecting children's services. Elected members do not always effectively hold officers to account, and assure themselves that children's needs are being identified and met. They do not currently offer consistent and high quality critical challenge and scrutiny to the work of children's social care, or act as effective corporate parents.

164. The Corporate Parenting Panel is constituted appropriately. Young people regularly attend the panel. Young people from the Children in Care Council told inspectors that they have regular contact with elected members and senior managers. Corporate parenting training is mandatory for elected members and all the cabinet have been briefed on child sexual exploitation. Members of the panel are committed to improving outcomes for children in care, and there are cogent examples of them promoting and supporting looked after children and young people to succeed, including financial support for young people to progress into higher education, staying put policies and access to social housing. However, the panel's work is underdeveloped. Members of the panel do not have sufficient detailed knowledge about the deterioration in the quality of services for looked after children since the last inspection. Members

recognise that they need to do more to fulfil their responsibilities for the considerable number of looked after children who live more than 20 miles from Lambeth and they have plans in place to visit young people in residential homes. The new Lead Member, appointed in November 2014, reads all of the MASE minutes and looks at the Director's critical log and data on missing episodes. However, it is too soon to evidence impact of this work.

165. A test of assurance in 2014, by the previous Chief Executive, resulted in the transfer of the statutory role of Director of Children's Services (DCS) to the Strategic Director of Delivery (SDD) in December 2014. Prior to this the SDD had operational responsibility for children's social care. In addition to the DCS role, the SDD is accountable for delivery across extensive key services which include Adults, Communities, Environment, Housing, Education and Business Growth. This broad span of responsibilities significantly impacts upon the ability of the DCS to maintain sufficient oversight and focus on children's services.

166. During 2013–14 a significant number of senior experienced children's services managers left Lambeth. This has reduced the capacity of senior managers to ensure that the service is effective and that the standards of practice and management oversight within children's services are of an acceptable or required level.

167. Local authority elected members, the interim Chief Executive and senior officers are clear about their respective roles, and clear lines of accountability have now been established to ensure that they discharge their individual and collective responsibilities. Senior leaders and members have a weekly 'Towards Excellence' meeting, which focuses on performance across the directorates. Matters relating to improving children's services are regularly discussed, and the authority is in the process of redesigning children's social care services.

168. The Lambeth Children and Families Strategic Partnership (CFSP), formed in 2013, is the key strategic partnership relating to children's services overall. The CFSP enables statutory and non-statutory agencies to work together for children, young people and their families, both in planning and delivering services. Commissioning activity is clearly aligned to the strategic planning process, and is overseen by chief officers. However, governance arrangements and priorities between key strategic boards and the LSCB are not well established.

169. The Joint Strategic Needs Assessment (JSNA) has informed and aligned priorities across the CFSP, the Health and Wellbeing Board, and the Early Intervention and Outcomes panels. The JSNA has driven targets and service commissioning in some areas, however, further work is needed to ensure that it links to targets and service commissioning in all priority areas.

170. The revised workforce strategy is appropriately focused on developing and retaining strong frontline services. The service has 420 established posts, of which 315 are filled on a permanent or fixed term basis. The service currently

includes 151 agency workers, a number of whom are in addition to established posts, including key senior management posts. Staff turnover for the year to December 2014 was 9.5% for the permanent workforce and significantly greater amongst agency workers. This lack of stability has negatively affected the quality and continuity of the social work service received by some children and their families, and has caused difficulties in communication for some partner agencies. Over 50% of agency posts are additional to the establishment. The local authority has committed to retaining additional staff until a complete service redesign is concluded later in 2015. This is to ensure a consistent focus on safeguarding children during a period of substantial change.

171. The local authority has invested considerable resources to ensure that caseloads are manageable and that all work is allocated. Staffing levels have been maintained that are significantly above the permanent established complement. Social work teams are well resourced and social work caseloads, averaging 15 children and young people, are manageable. Many of the over-establishment posts are filled by agency staff. This has led to some recent improvements to raise standards of practice to at least a minimum level. However, inspectors still found some staff and managers failing to comply with basic social work standards. Recording is poor in too many case files, some assessments lack sufficient historical analysis, and a number of plans are of a poor quality. New senior managers are actively intervening to improve practice, but it is too soon to evaluate whether changes will be sustained.

172. A clear professional development framework is in place for all newly qualified social workers during their assessed and supported year in employment (ASYE). This includes comprehensive induction and a range of mandatory training. Case loads are protected and newly qualified workers report that they feel supported in their teams.

173. Complaints are managed well by a designated complaints manager. Learning from complaints is cascaded to managers. The local authority appropriately made four serious incident notifications to Ofsted in the past three years. Three serious case reviews have been undertaken, one of which has been completed and two are yet to be published. Learning from serious case reviews is disseminated effectively.

174. The quality of work going through the family court has recently improved, but remains too variable. Cafcass and the District Family Judge report that neglect cases are not coming to court soon enough. While they report some examples of good work, generally social workers from Lambeth are not perceived to be good at representing their cases. There is inconsistency in work being undertaken pre-proceedings, with some cases missing key information and others being of poor quality. Frequent changes in social workers are reported to negatively affect the quality of work and are causing delay for some children. This was confirmed in cases seen by inspectors. Lambeth is a high issuing authority, consistently bringing around 100 cases to court each year. The average length of proceedings at the time of inspection was 38 weeks, which is

similar to other inner city boroughs. Court outcomes are broadly similar to statistical neighbours, with 37% of children subject to supervision orders, 28% of cases with special guardianship orders made and 20% of children subject to care orders. Guardians spoke positively about Signs of Safety conferences resulting in increased engagement from families. Lambeth is perceived by partners as a very active member of the South London Care Proceedings Project.

175. A wide range of multi-agency early help services has been established and maintained in Lambeth, underpinned by an extensive variety of voluntary and faith sector initiatives. These are supported well by an holistic, multi-agency early intervention commissioning strategy 2013–14, which was reviewed in 2014, and a Community Plan which spans universal, targeted and specialist services. These services effectively help families and children at risk and contribute to preventing the escalation of concerns to targeted services.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is inadequate
The arrangements in place to evaluate the effectiveness of what is done by the authority and board partners to safeguard and promote the welfare of children are inadequate.

Summary of findings

The LSCB is inadequate because:

Scrutiny, awareness and challenge

- Throughout 2014 the LSCB has not effectively carried out its statutory functions. These issues have now been recognised and new LSCB structures, membership and operational groups have been established in 2015, but it is too early to identify the impact.
- The LSCB has not been sufficiently independent from its key partners and has not adequately influenced the prioritisation of safeguarding children amongst other strategic fora or exerted challenge to other partners or organisations.
- Oversight of multi-agency work to prevent child sexual exploitation was not effectively maintained through 2014, although this has been revived in 2015.

Quality and evaluation

- The LSCB does not have effective quality assurance information or analysis of the performance of the board or its partners. It has not systematically assured itself that all partners have appropriate safeguarding policies, practices and procedures in place or that these are being followed.
- The Board has not sufficiently assured itself, through multi-agency case audits, that the standards of safeguarding practice are of required standards.
- The work of the Board has not been effectively progressed through its operational groups and through the business support provided.
- Multi-agency training has been maintained, but its impact on improving safeguarding practice has not been rigorously evaluated.

What does the LSCB need to improve?

Priority and immediate action

176. Ensure that the operational sub-groups of the LSCB are firmly established, appropriately represented and effectively carry out the Board's work programme.

177. Ensure that the work programme is incorporated into revised strategic and operational plans for the Board.

178. Ensure that key multi-agency safeguarding performance management information required by the Board is agreed, regularly collated and analysed by partners to enable the Board to evaluate the impact of its work to safeguard children.

179. Ensure that a programme of multi-agency case audits of safeguarding practice is implemented and the findings are utilised to improve practice and to develop services.

Areas for improvement

Scrutiny, awareness and challenge

180. Ensure that governance arrangements between the LSCB and other key strategic groups, including the Health and Wellbeing Board and the Children and Families Strategic Partnership, are formalised and influence and inform each other's work.

181. Ensure that all partners are actively engaged in the work of the Board and representatives at the right level regularly attend and contribute to the Board's working groups.

182. Ensure that the LSCB is sufficiently independent from local authority children's services.

183. Ensure that the Board and all its partners monitor the effectiveness of local safeguarding policies, procedures and practices and that these are followed by staff.

184. Ensure that all partners fully support the work of the Board through proportional contribution of resources, including financial contributions.

Quality and evaluation

185. Ensure that the business and administrative support to the Board is effective, is sufficiently resourced and is independent from the work of the local authority children's services.

186. Ensure that all actions from serious case reviews are progressed in a timely manner.

187. Ensure that multi-agency safeguarding thresholds are clearly established on behalf of the Board and are understood and consistently applied by partners.

188. Ensure that the Board effectively monitors and contributes to the development of safeguarding within early help services and services for looked after children and care leavers.

189. Ensure that multi-agency safeguarding training and the impact that this has on practice are rigorously evaluated.

Inspection judgement about the LSCB

190. The LSCB did not effectively carry out its core statutory functions in 2014. Its operational groups were not sufficiently represented by key partners and most did not effectively carry out their work programmes. This was recognised in July 2014 at an LSCB development event, and through a mock inspection of the LSCB functions undertaken in November 2014. As a result, the LSCB has agreed major structural and operational changes. Most of these are only beginning to take shape in early 2015.

191. Significant staffing changes in the business and administrative support to the LSCB and in the senior staff within key partner agencies, particularly children's social care services, have had a negative impact on the continuity and the consistency of the work of the LSCB and its sub groups. Between July and December 2014 the work of the LSCB was fragmented. Partners were unclear how the operational work of the Board was being progressed and whether its sub-groups and working groups were disbanded or continued to operate. Some of the work areas tasked to sub-groups were undertaken 'off line' by committed individuals, instead of being done systematically through established multi-agency fora.

192. The LSCB Chair, who is well-respected by partner agencies, and the recently appointed LSCB Manager, are committed to facilitating the significant LSCB structural changes to improve the work and profile of the Board. In recent months they have met with a wide range of partners at all levels to help to improve their engagement and to promote the work and profile of the Board, and this has resulted in increased engagement by partners in the Board's work.

193. Formal governance arrangements between the LSCB and other key strategic bodies, such as the Health and Wellbeing Board and Lambeth Children and Families Strategic Partnership (CFSP), are not sufficiently well-established. While the LSCB Chair is a member of the CFSP, the LSCB has had little direct input or influence on the work or priorities of these boards. The LSCB has recognised this and has very recently drafted a protocol with the Health and Wellbeing Board. Governance arrangements between the LSCB and the Adults'

Safeguarding Board are well-established, and are facilitated by having the same chairperson.

194. The LSCB has rightly been viewed by partner agencies as being too much a part of the local authority's children's services and not sufficiently independent from the local authority. This has been exacerbated by the business and administrative support to the LSCB and the Board Manager being managed through the local authority children's services. A new Board Manager was appointed in 2015, and is attempting to rationalise the work of the Board, although, at the time of the inspection, this remained fragmented and work was at an early stage of development.

195. The LSCB has been too large, often with overrepresentation by local authority children's services staff, whereas many of its sub-committees have been underrepresented by key partners, or not quorate to effectively progress the work of the Board. The LSCB has reviewed its structure and that of its sub-groups. In 2015 the Board implemented new structures and terms of reference for an LSCB executive and the Board itself, and streamlined sub-groups and working groups. However, it is too early to assess their effectiveness, as most have only recently agreed terms of reference, membership and work plans.

196. The LSCB has not ensured regular or effective monitoring of frontline practice to safeguard children. A performance sub-group of the LSCB, primarily tasked to review and analyse multi-agency performance information, had undertaken this function sufficiently prior to 2014. It did not, however, sustain regular or rigorous oversight throughout 2014. A performance information digest, based largely on the local authority's performance data, has been regularly produced and reported to the LSCB. However, in recent years this extensive data set has not been reviewed by the Board, to ensure that it provides the most relevant information to enable board partners to oversee the quality of safeguarding practice. Little supporting analysis has been provided to enable LSCB members to interrogate the information or to exert challenge to each other. A draft proposal for a new performance management framework has been developed within the local authority children's services, which is to be considered by LSCB partners.

197. The LSCB has not systematically used case file audits to improve multi-agency professional practice. Some partner agencies have undertaken individual case audits which have been used to improve practice within their own services, and some of these have been reported to the LSCB. The LSCB only undertook one multi-agency case audit in 2014, of a few cases relating to children with disabilities. This was not repeated to establish if the issues resulting from the audit had been tackled. The LSCB has not implemented a planned schedule of multi-agency audits, as a result of work pressures and restructuring.

198. The LSCB, through its performance-sub group, did robustly review and contribute to the development of the Early Help Strategy in 2013. However, the strategy was further developed in 2014, but the LSCB did not maintain its

overview or contribute to its redevelopment. The LSCB has received annual reports from the Corporate Parenting Panel, but not from the Independent Reviewing service. It has not effectively overseen the safeguarding needs of looked after children and those placed outside the area.

199. Other than through the serious case review processes, there is little evidence that partners challenge or hold each other to account for their contribution to the safety and protection of children. No examples were seen where the LSCB Chair has formally raised challenges or issues of concern on behalf of the LSCB, although often issues have been raised informally. In LSCB meetings in 2014, a voluntary sector representative did appropriately raise concerns about the impact of frequent changes of social workers on children. It is not clear what action resulted from this.

200. The LSCB recognised the need to review, update and confirm with its partners its commitment to safeguarding children. Partners were required during 2014 to confirm that they had appropriate safeguarding practices, policies and procedures under section 11 of the Children Act 2004 and also, specifically, in relation to domestic violence and female genital mutilation. However, while a few key agencies did report to the Board, this was not systematically completed. The LSCB did not monitor or challenge partners who did not complete this activity. The LSCB recognised in 2014 that there has been slippage in the programme of section 11 audits, and raised concerns about whether local schools and voluntary sector organisations had submitted returns. However, this was not effectively tackled and the Board has not taken action to ensure that these organisations provide required information.

201. Health partners actively engage in the work of the LSCB. They are routinely represented on the Board and relevant sub-groups. The Child Death Overview Panel has carried out its functions appropriately throughout the period of structural changes to the Board and has submitted relevant reports. A new Health Network sub-group of the LSCB was established in January 2015, appropriately expanding and incorporating the work of the existing health, safeguarding and looked after children group. Police engagement in the work of the LSCB has been enhanced in recent months, particularly through joint chairing of the new Child Exploitation sub-group, to oversee areas where the police actively engage in multi-agency work to safeguard children.

202. LSCB partners have not made proportionate financial contributions to the work of the Board, including the significant costs of the serious case reviews undertaken in the area. A disproportionate amount of the costs has been met by the local authority's children's services. This has exacerbated the dominance of the local authority on the Board and the issue of the Board's perceived lack of independence. Proposals to realign the financial contribution of partners were being considered at the time of this inspection.

203. Since the last inspection of safeguarding services in 2012, the LSCB has commissioned and overseen three serious case reviews (SCRs). Two of these

await publication. These reviews absorbed a significant amount of resources and time from LSCB partners and from the administrative support to the Board. Learning from these SCRs has been widely disseminated across staff of partner organisations and within the community through a series of events and training seminars. Staff from partner agencies were able to articulate this learning and apply it to their work. The serious case review sub-committee of the LSCB has appropriately considered serious incidents and whether to instigate multi-agency or individual agency reviews. It has effectively developed and monitored action plans arising from these and reported to the LSCB on progress. However, progress on aspects of these plans has been delayed as a result of pressures in the LSCB business and administrative support, and also where tasks have fallen to other LSCB groups which have not functioned effectively. For example, multi-agency audits of practice related to SCR recommendations have not been completed as planned.

204. The policies and procedures of the LSCB are primarily based on the pan-London procedures, with little review or modification for local issues. They are fit for purpose. The LSCB Chair is a member of the pan-London chairs' group and has contributed to the development of pan-London protocols. Some localised procedures have been developed, for example on child sexual exploitation and on youth violence. However, the LSCB has not monitored or evaluated the effectiveness of local safeguarding policies and procedures or the adherence to them by its partners.

205. The LSCB has not systematically reviewed safeguarding thresholds, or their application, with partners and has not published a thresholds document as prescribed in *Working Together 2013*. It has monitored the application of some thresholds locally, through its oversight of the multi-agency safeguarding hub.

206. The LSCB has recently established a child exploitation sub-group, which began in January 2015 to oversee multi-agency work on child sexual exploitation and missing children, linked to related issues such as gangs. This group is developing the work of previous LSCB sub-committees, which established core policies and processes in early 2014, but whose work programmes were not systematically progressed through the later part of 2014. In the interim, oversight of multi-agency performance in these areas was maintained through operational groups, such as the MASE. The work of the Local Authority Designated Officer has also been maintained, but not sufficiently monitored through the LSCB.

207. In 2013 and early 2014 the LSCB engaged well with a group of young people, 'Young Lambeth Voice', using their views and experiences to inform the development of strategies and services, for example on children missing, e-safety, bullying and other aspects of the Board's work. However, during mid-2014 this group ceased to meet regularly or to be supported, and as a result the LSCB is not currently informed by young people or service users as it undertakes a major restructuring of its role and activities.

208. Over recent years the LSCB has not been a key influence in the planning of services for children and young people in Lambeth. Its lack of independence from the local authority children's services has meant that its work has largely been determined by and dependent on issues affecting those services, in particular the changes to children's services senior management and to the administrative support to the Board. This has been recognised by the LSCB and the local authority and the new LSCB structure and membership has been designed to increase the engagement of partner agencies at all levels. It is too early to assess if this will have the intended impact. The LSCB has made limited use of its scrutiny role or statutory powers to influence priority setting across strategic partners, although there are areas which overlap, for example in the extensive gang related work undertaken in the area.

209. A wide range of well-established multi-agency safeguarding training has been provided through the LSCB to partners and within the local community. This has been updated to include current local and national issues affecting children and their families, for example gang related issues and child sexual exploitation. Training has been expanded into e-learning modules. Staff from partner agencies report that they are readily able to access a range of training, and that it has helped to raise awareness of key safeguarding issues. Evaluation of the impact of training has been basic and primarily based on self-evaluation by participants, which has been largely positive. The LSCB has begun to pilot more sophisticated evaluation of the impact of training on safeguarding practice, based on recently published pan-London guidance.

210. A local learning and improvement framework has been developed by staff within children's social care services for consideration by LSCB partners. This is still in draft form. Awareness of safeguarding issues across partners and the local community is supported by a range of information published by the LSCB, including through its website. Information has not been regularly reviewed or kept up to date due to pressures on the Board's business and administrative support, but efforts have been made in recent months to do so.

211. The LSCB annual report for March 2013 to April 2014 was published in January 2015, having been delayed due to work and staffing pressures in the Board's administration. It provides a brief description of the activities undertaken by the Board and a synopsis of the key safeguarding issues in the area. It does not provide sufficient evaluation of what impact the LSCB is having on these issues. The report does not rigorously assess the performance or effectiveness of local safeguarding services or identify areas of weakness. It does provide a synopsis of issues arising and lessons learnt from local serious case reviews. Late publication of the report enabled it to include areas that were identified in mid-2014, such as the imbalance of local authority representatives on the Board, the variation of seniority across all agencies and the need for structural changes across the LSCB. These issues have been now been tackled through the LSCB Chair and reinvigorated commitment from partners. Structural changes have been agreed and most have been implemented in 2015. However, it is too early

to demonstrate that these are embedded or have improved the effectiveness of the Board.

212. The LSCB reviewed its priorities in 2014 and these remain appropriate. Its business plan has not been revised to incorporate the significant changes to its structure, operation and work priorities that have been agreed by partners and have begun to be implemented.

What the inspection judgements mean

The local authority

An **outstanding** local authority leads highly effective services that contribute to significantly improved outcomes for children and young people who need help and protection and care. Their progress exceeds expectations and is sustained over time.

A **good** local authority leads effective services that help, protect and care for children and young people and those who are looked after and care leavers have their welfare safeguarded and promoted.

In a local authority that **requires improvement**, there are no widespread or serious failures that create or leave children being harmed or at risk of harm. The welfare of looked after children is safeguarded and promoted. Minimum requirements are in place, however, the authority is not yet delivering good protection, help and care for children, young people and families.

A local authority that is **inadequate** is providing services where there are widespread or serious failures that create or leave children being harmed or at risk of harm or result in children looked after or care leavers not having their welfare safeguarded and promoted.

The LSCB

An **outstanding** LSCB is highly influential in improving the care and protection of children. Their evaluation of performance is exceptional and helps the local authority and its partners to understand the difference that services make and where they need to improve. The LSCB creates and fosters an effective learning culture.

An LSCB that is **good** coordinates the activity of statutory partners and monitors the effectiveness of local arrangements. Multi-agency training in the protection and care of children is effective and evaluated regularly for impact. The LSCB provides robust and rigorous evaluation and analysis of local performance that identifies areas for improvement and influences the planning and delivery of high-quality services.

An LSCB **requires improvement** if it does not yet demonstrate the characteristics of good.

An LSCB that is **inadequate** does not demonstrate that it has effective arrangements in place and the required skills to discharge its statutory functions. It does not understand the experiences of children and young people locally and fails to identify where improvements can be made.

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 six of Her Majesty's Inspectors (HMI) from Ofsted and two associate inspectors.

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