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Dear Annie

Monitoring visit to Lambeth children's services

This letter summarises the findings of the monitoring visit to Lambeth children's services on 26 and 27 July 2016. This was the fourth visit by Ofsted since the local authority was judged inadequate for overall effectiveness in February 2015. The inspectors were Brenda McLaughlin and Louise Hocking.

Inspectors have consistently identified serious and widespread failings in the quality of services for children and families. The local authority is making some progress to improve services for children and young people, but the pace of change continues to be slow.

Following the monitoring visit in March 2016, the local authority carried out a fundamental review of its comprehensive improvement plan, to ensure that senior managers maintain a focus on children who are currently in need of help and protection, as well as planning for the future. While the local authority is beginning to demonstrate some progress to improve services for its children, the pace of change needs to accelerate. Despite the increase in senior management capacity, inspectors have continued to identify recent poor practice that is leaving too many children unprotected.

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Areas covered by the visit

During the course of this visit, inspectors reviewed the progress made in the areas of help and protection, including:

- the quality of management decision-making in the multi-agency safeguarding hub (MASH) and the application of thresholds for statutory intervention
- the quality of assessments and plans and whether they are improving outcomes for children and their families at the 'front-door'
- safeguarding arrangements in the child assessment team (CAT)
- a review of the local authority's arrangements to protect children at risk of sexual exploitation and those missing from home and care.

The visit considered a range of evidence, including electronic case records, supervision records, performance data, audits and progress reports. We observed social workers undertaking referral duties. We spoke to a range of staff, including managers, child protection case conference chairs, social workers, the specialist child sexual exploitation worker, the early help coordinator and referral and assessment support officers.

Summary of findings

- Overall, management oversight is inconsistent and weak. Additional senior management capacity since May 2016 has enabled senior managers to begin to put in place quality assurance systems so that managers at all levels know what is happening to children. It is too soon to see the impact of these positive changes. However, staff morale is good. Social workers told inspectors that they are listened to and feel supported.

- The recruitment and retention of staff is a priority and challenge for Lambeth. While it is successfully recruiting permanently to senior and middle manager posts, attracting high-calibre permanent team managers is difficult. The service currently relies on high numbers of agency staff, many of whom are experienced. However, changes in staffing lead to some children experiencing poor quality work and delays in services.

- Contacts and referrals from other agencies are high. At the time of the visit, there had been over 800 contacts in the previous week and in excess of 350 referrals in July, leading to increased assessments. This is causing significant pressure in a system already under stress. More work is required by the Lambeth Safeguarding Children Board and partner agencies to ensure thresholds for statutory services are fully understood.

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- Threshold decisions made by experienced social workers and their managers in the MASH and in the first response team are timely and effective in identifying children at risk of harm. Cases are prioritised and promptly transferred to the CAT team on duty. The inclusion of the early help coordinator in the MASH is improving the quality of the threshold decision-making to step children down to universal and targeted support services.

- Caseloads are high in the five CAT teams, with most social workers responsible for over 20 children. Some workers have inherited cases where there is a legacy of inadequate practice and the current workers do not have the capacity to carry out good quality interventions. As a consequence, while the timeliness of assessments is improving, most are not child centred, with poor analysis of risk and a failure to fully consider historical factors.

- In cases tracked and sampled by inspectors, including some of those audited by the local authority, a failure of management oversight means that too many children are not being helped and protected effectively. Inspectors referred a number of cases where actions identified in audits had not been carried out, leaving children exposed to unacceptable delay and risk. Senior leaders had not been aware of this until inspectors selected these cases to track on this visit.

- Strategy discussions do not always take place in a timely way. The majority are still with the police only, via telephone, with information from other agencies not consistently available at the enquiry stage. In better cases, partner agencies are involved and contribute to decision-making, risk analysis is good and prompt action is taken to safeguard children.

- The quality of section 47 enquiries seen by inspectors varied considerably. It ranged from good, timely interventions to safeguard children through the child protection processes to delays in convening child protection conferences, with children left unseen in situations of high risk.

- Recording in case files is improving in some teams, with helpful case summaries that identify the main issues. However, in some child protection and child in need cases, it was not clear whether visits to very vulnerable children were taking place routinely. Inspectors brought these cases to the attention of the local authority, for example, where serious incident notifications from the police in a small number of cases did not result in visits to children at home.

- The quality of social work supervision is not yet consistently good enough but its frequency is improving. There is more evidence of management case direction on children’s files and the introduction of reflective and group

supervision is helping to build confidence. While this is a significant improvement since the last visit, middle and senior managers must ensure that supervision is effective in improving safeguarding arrangements for all children.

- Performance management systems are improving, with senior managers involved in auditing cases. The introduction of a quarterly 'practice week' means that managers at all levels are involved in auditing frontline practice. A revised quality assurance and new practice framework is in the process of being rolled out under the leadership of the interim director of children's services. This monitoring visit identified that a systematic approach to ensure that audit findings are followed through by frontline managers is required immediately. In addition, weekly accessible performance information needs to be used by staff to drive improvement across all teams.

- Managers recognise that arrangements to protect children missing from home, education and care are underdeveloped. They are in the process of appointing a 'missing children' coordinator. Return home interviews (after children go missing) are not undertaken consistently. There is no corporate system for aggregating or cross-referencing information from return home interviews with those children at risk of being, or being, sexually exploited or those at risk of being involved in gang activity.

- Strategic arrangements for understanding, analysing and evaluating outcomes for children at risk of sexual exploitation are inconsistent and uncoordinated. Instead, there is a piecemeal, case-by-case approach. Inspectors referred cases where children who had been on child protection plans for over 12 months had not been effectively protected from harm. A child sexual abuse coordinator, based in the MASH, is responsible for an extensive range of activity. This includes, for example, monitoring individual children who are at high risk, chairing strategy meetings on individual children, chairing of the multi-agency review panel, raising awareness across the partnership and providing consultation and advice to staff and professionals across Lambeth. At the time of the visit, there were 34 children identified as high risk, plus a list of over 300 children deemed to be at low risk. There is an absence of management oversight of these activities.

Evaluation of progress

The 2015 single inspection identified significant failures to safeguard children. These included the need to ensure that:

- all young people who go missing from home and care are promptly and appropriately seen on 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

- all relevant agencies are consulted and contribute to planning during child protection enquiries
- the progress of child protection and child in need plans when reviewed in meetings and in supervision is focused on the reduction of risk
- the consistency of recording, frequency of visits and quality of social work practice within the disabled children's team are of a high standard
- 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
- 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 for vulnerable children and young people.

Overall, this visit found limited progress in most of these areas. However, the appointment in May 2016 of an interim director of children's services and of permanent senior managers and middle managers is bringing stronger leadership, clarity on priorities and a focus on frontline practice. Senior leaders have a realistic understanding of the challenges facing children's services and are taking action to address the significant deficits identified during this visit. Nevertheless, many of the improvement measures are not yet in place or have been too recent to make a difference. Leaders accept Ofsted's findings that too many vulnerable children are being insufficiently helped and safeguarded from harm. The changes required need to accelerate considerably.

I am copying this letter to the Department for Education. This letter will be published on the Ofsted website.

Yours sincerely

Brenda McLaughlin

Her Majesty's Inspector