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Dear Annie

Monitoring visit to London Borough of Lambeth children's services

This letter summarises the findings of the monitoring visit to Lambeth children's services on 4 and 5 April 2017. This was the sixth visit since the local authority was judged inadequate in February 2015. The inspectors were Brenda McLaughlin HMI, Louise Hocking HMI and Marcie Taylor HMI.

The local authority is continuing to make progress from a low base. Action taken by senior leaders and managers since previous visits is significantly improving consistency in the quality of social work practice and management oversight. As a result, more children are being helped and protected from harm. Leaders have a comprehensive knowledge of their strengths, areas of weakness and the challenges that they face to embed the considerable positive changes that they have made. They are relentlessly focused on addressing poor practice, but recognise that there is much more to do to ensure that risks to all children are fully understood and responded to. In the cases sampled and tracked, a small number of children were referred to senior managers as a result of weak operational practice in helping and protecting sexually exploited children and those missing from home and care.

Areas covered by the visit

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

- the quality of practice for children with disabilities
- the quality of practice and planning for care leavers
- the quality of practice in protecting children missing from home and care or at risk of sexual exploitation.

The visit considered a range of evidence, including electronic case records, supervision files and notes. We reviewed improvement plans, the local authority 'stock take' self-assessment and performance information and commented on the quality and impact of audit activity and the effectiveness of management oversight. In addition, we spoke to a range of staff, including managers, the principal social worker, personal advisers and social workers.

Overview

Overall, this visit found that an increasing number of children and young people are safer as a result of better-quality child-centred practice and more consistent management oversight. Visits to children are mostly timely, and there is stronger evidence of purposeful direct work, leading to a better understanding of children's lived experiences. Recording on the majority of children's files is generally up to date, and case summaries in most cases seen provide a useful analysis of areas of concerns and progress. Social workers and personal advisers know children and young people well. The quality and frequency of supervision have improved. Staff report that caseloads are manageable. They have welcomed the extensive learning and development opportunities and have benefited from the targeted work provided by advanced practitioners. They feel supported and listened to by managers and senior leaders. However, the local authority is fully aware from its own audits, an external peer review, practice weeks and performance information and clinics that the quality of work remains too variable. During this visit, this was particularly evident in the failure to conduct return home interviews for too many children missing from home and care and, in a small number of cases, inconsistent identification of risks and plans to protect children and young people from sexual exploitation and gang activity.

Findings and evaluation of progress

A dedicated focus on services for children with disabilities, led by the new permanent service manager, is beginning to have a positive impact on ensuring that practitioners develop skills and confidence so that vulnerable children with additional needs are helped and protected from harm. Children are now visited frequently, and timely reviews are taking place. Permanency planning is appropriately considered for children looked after with disabilities, and they live in secure placements with committed carers. The timeliness and quality of permanency work are variable and, in a small number of cases seen, delays or changes to practical or financial support had the potential to affect the stability of the placement. Some children have a current assessment based on a clear understanding of their needs, and their plans

are analytical, clear and child centred, but this is not consistent for every child. Clear case summaries and up-to-date recording were present on all records seen, along with considerably improved supervision and management oversight. The 'step down' process from child in need, assisted by a well-chaired resource panel, is starting to ensure that disabled children and their families receive appropriate continuing packages of support that are not intrusive or disproportionate to the needs of the child and the family.

Following a targeted approach by the now-permanent leaving care management team, the quality of practice to care leavers is beginning to improve, albeit from a low base. Most care leavers (89%) now have a pathway plan. This is a significant improvement from 51% in January 2017. Although variable in quality, pathway plans seen by inspectors had all been completed within required timescales. Most plans directly involve young people, and their views and wishes are clearly recorded. Better plans contain comprehensive, detailed, specific actions carried out within identified timescales, helping vulnerable and often troubled young people to access support, training and employment. However, too many plans lack focus on individual needs, resulting in delays in achieving key aspects of the plan, for example failure to meet the needs of some vulnerable care leavers in custody.

All personal advisers and social workers spoken to know their young people well, but the quality of their practice and the impact for the care leavers are not consistently captured in case file recording. Young people are visited regularly, but the purpose of the visit, linked to actions identified in the pathway plans, is not always clear, making it difficult to see how the plan is progressed. In most cases seen, there is evidence of supervision taking place, although not frequently enough in cases where young people have been identified as particularly vulnerable. No files seen by inspectors showed that actions are monitored in next and subsequent supervision sessions. This has resulted in delays in taking forward important issues raised by some young people.

Most young people are supported effectively to live in semi-supported accommodation suitable for their needs and in line with their wishes. The local authority is actively supporting those care leavers who have rent arrears to manage their payments, which is helping them to retain their homes. However, more work is required to fully equip young people to achieve and sustain independence. In most cases, the health needs of young people are identified, but plans lack sufficient detail and clarity to explain fully how these will be met. When mental health issues are identified, the support to help young people to access appropriate services is inconsistent. For example, actions mostly rely on the young person going to their general practitioner, even when there is a previous history of poor engagement with this service. Assessment of sexual health needs is lacking in most cases, despite serious risks identified. Work to ensure effective health histories is not yet in place in most cases.

Too many care leavers are not in education, employment or training. The numbers supported into employment or apprenticeships through the 'steps to success'

programme are low. However, this is a positive development for young people who are difficult to engage. The risk of child sexual exploitation is not effectively or consistently considered for this group of vulnerable young people. The pathway plan format does not include sufficient reference to risk or vulnerabilities in key areas such as 'missing', gang activity or child sexual exploitation.

The arrangements to monitor and track children and young people who go missing from home or care have been strengthened by the appointment of the 'missing' coordinator in September 2016. The recording system is more accurate, enabling better senior management oversight. Information sharing has improved, and there are effective links with a range of professionals that include the gangs multi-agency panel, the youth offending risk panel and the multi-agency risk panel (MARP), which is helping to focus more effectively on individual cases. However, operational social work practice remains weak; this has been evident since the inspection in 2015. There is too much focus on process. In most of the cases seen by inspectors, there were no return home interviews and there were delays in a significant number that did take place. As a result, the opportunity to uncover vital information, identify risks and take timely protective action was lost, leaving too many children at continuing risk.

The response and assessment for children at risk of sexual exploitation, while gradually improving, remain inconsistent. Inspectors referred a number of children for whom child protection thresholds were not applied consistently or there had been delay in recognising and addressing risk early enough. Senior leaders agree that the MARP needs to be reviewed to ensure that the rationale for decisions is supported by clear evidence that risks are being reduced and improvements sustained. The local authority recognises that, at a strategic level, it needs to understand better and analyse the connections between child sexual exploitation, missing children, youth violence and gangs. A multi-agency group has been set up by the Local Safeguarding Children Board and chaired by the director of children's services to address these issues.

To summarise, the evidence gathered during this visit has identified substantial recent improvement in the quality of practice and management oversight, helping and protecting many more children from harm. Leaders and managers demonstrate considerable determination, tenacity and commitment to embedding and sustaining these changes, while simultaneously addressing the areas of poor practice.

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