Medway

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: 14 September to 8 October 2015

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

Executive summary

This executive summary should be read alongside the recommendations in the next section of this report. Each recommendation is clearly linked to the relevant paragraph(s) that set out the detailed findings of this inspection.

Children's services in Medway require improvement to be good. Services have improved from 2013, when they were found to be inadequate. Over the past two years, the Medway Improvement Board (MIB) and senior local authority and political leaders have worked together effectively. This has led to positive changes in the experiences of children and young people in most of the areas identified for

[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.

improvement in previous inspections. Some practice remains weak or inconsistent. In a few areas, for example the quality of support provided to care leavers, practice is now good.

Senior and political leaders understand well the strengths and weaknesses within services for children who need help, protection and care. External scrutiny, such as peer review, has been welcomed and acted on. The impact of internal overview and scrutiny is clearly evident. Learning from complaints is well embedded and senior managers take careful account of young people's views. The corporate parenting board is a strong and effective forum for challenging and improving the experiences of children looked after. Within a comprehensive quality assurance framework, regular case auditing has been established and performance management information is robust.

Leaders, managers and partners are committed to further improvement. Strategic plans are appropriately aligned and strong political support is evidenced through substantial financial investment in core social work teams. In the past two years, 75 new permanent social workers have been appointed and caseloads are reducing as a result. This is a vital step in Medway's improvement journey. A stable senior management team is in place. These managers have maintained a firm commitment to recruiting good-quality staff. The proportion of agency staff at social work and first line manager level remains high, directly linked to the increase in overall staffing levels. Reliance on agency staff has led to disrupted social work relationships for some children. In these cases, progress against plans has been slow. Senior managers are doing the right things to address workforce challenges. In particular, high quality professional support is provided through the social work academy.

Regular case supervision is evident and often detailed, although formal staff supervision is weaker. Managers do not always make sure that plans for children are progressed assertively, or utilise performance information effectively in their oversight of key areas of core social work practice. For example, multi-agency plans for children who are subject to child in need and child protection plans are not as effective as they should be. Child protection core groups do not consistently review or progress plans. Similarly, managers have not provided effective oversight and management of pre-proceedings work within the Public Law Outline. This is leading to delays in improving outcomes for some children.

Partnership working has improved considerably since the last inspection, particularly in ensuring a robust multi-agency response to referrals to children's social care. The contact, advice and duty service (CADS) responds efficiently to new referrals in most cases and thresholds to decide what help families need are effectively applied. Some contacts take too long to progress and, for these families, help can be delayed. Risk within families is responded to well, but some interim and contingency plans lack enough detail to ensure that arrangements to safeguard children are clear while awaiting next steps. Strategic and operational arrangements for responding to families experiencing domestic violence, and to children who go missing or who are at risk of child sexual exploitation, are strong overall. However, children who go missing are not consistently seen soon enough after they return.

Children looked after live in stable placements that meet their needs well. However,

not all children looked after have a formal permanency plan at the right time. Connected persons and special guardianship arrangements are frequently considered as a permanence option for children, but assessments to consider the appropriateness of these arrangements are not always progressed in a timely way.

When children return home from care, professionals do not always review what help these families need to reduce the likelihood that problems will return. Independent Reviewing Officers (IROs) take an active interest in the progress and experiences of children looked after. However, managers and IROs do not consistently accelerate plans for permanence. Younger children are being adopted and timescales are improving, but older children also need to be able to live in adoptive homes and in good time. Child permanence reports and later-life letters are not consistently good enough. Decisions made by the Agency Decision Maker (ADM) about children to be adopted, although timely, lack detail and rationale.

Commissioning relationships are strong and partners are addressing gaps, but there is further work to be done. For example, the health needs of newly looked after children are not assessed quickly enough by health professionals. Child and adolescent mental health services (CAMHS) support is not sufficient to meet the needs of children looked after and care leavers. Too many children looked after do not see a dentist often enough.

When concerns are raised about professionals who work with children, these are responded to appropriately. However, increased workloads have reduced the ability of managers to oversee and track this work effectively.

A comprehensive needs analysis has resulted in the implementation of a clear early help strategy. Recent progress has been made but this has taken too long. The quality of early help assessments is improving. Further work is now needed to ensure that services for families at this level are consistently well coordinated and delivered, particularly after a period of social care involvement.

The quality and timeliness of assessments and the participation of children in looked after reviews and child protection conferences have markedly improved since the last inspection. Children's diverse needs are assessed and understood, but most care plans do not reflect the current needs of children looked after well enough. The quality of support for care leavers is now consistently good and young people's outcomes improve as a result. Further work is needed to reduce the attainment gap between children looked after and other children in Medway and to ensure that more care leavers are engaged in meaningful employment, training or education.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates two children's homes. One was judged to be good in their most recent Ofsted inspection and the other, which provides overnight respite for disabled children, was judged adequate.
- The previous inspection of the local authority's arrangements for the protection of children was in January 2013. The local authority was judged to be inadequate.
- The previous inspection of the local authority's services for children looked after was in July 2013. The local authority was judged to be inadequate.

Local leadership

- The Director of Children's Services (DCS) has been in post since September 2012.
- The DCS is also responsible for adult services and holds the statutory Director of Adult Services role.
- The chair of the Local Safeguarding Children Board (LSCB) has been in post since December 2014.

Children living in this area

- Approximately 62,536 children and young people under 18 years old live in Medway. This is 23% of the total population in the area.
- Approximately 21% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 16% (the national average is 16%)
  - in secondary schools is 13% (the national average is 14%).
- Children and young people from minority ethnic groups account for 14% 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 Asian/Asian British.

[2] 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.

- The proportion of children and young people who speak English as an additional language:
  - in primary schools is 13% (the national average is 19%).
  - in secondary schools is 9% (the national average is 15%).

Child protection in this area

- At 31 August 2015, 2,393 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 2,589 at 31 March 2014.
- At 31 August 2015, 469 children and young people were the subject of a child protection plan. This is an increase from 358 at 31 March 2014.
- At 31 August 2015, nine children lived in a privately arranged fostering placement. This is a reduction from 10 at 31 March 2014.
- Since the last inspection, six serious incident notifications have been submitted to Ofsted and three serious case reviews have been completed or were ongoing at the time of the inspection.

Children looked after in this area

- 31 August 2015, 433 children are being looked after by the local authority (a rate of 69 per 10,000 children). This is an increase from 425 (68 per 10,000 children) at 31 March 2015. Of this number:
  - 177 (or 41%) live outside the local authority area
  - 33 live in residential children's homes, of whom 88% live out of the authority area
  - one lives in a residential special school[3], which is outside of the authority area
  - 352 live with foster families, of whom 41% live out of the authority area
  - five live with parents, of whom one lives out of the authority area
  - three are unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been 29 adoptions
  - 20 children became the subject of special guardianship orders
  - a total of 184 children ceased to be looked after, of whom 3% subsequently returned to be looked after

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

- 11 children ceased to be looked after as a result of child arrangement orders
- 15 children and young people ceased to be looked after and moved on to independent living
- 12 children and young people ceased to be looked after and are now living in houses of multiple occupation.

Recommendations

1. Ensure that all managers use performance management information effectively to scrutinise and improve key areas of core social work practice, particularly in relation to:

    - the timely progression and regular review of contacts and referrals (paragraph 19)
    - the quality and timeliness of core groups and child in need reviews (paragraph 30)
    - the timely completion of connected persons and special guardianship assessments (paragraphs 43, 106)
    - the timeliness of return interviews for children who go missing, ensuring that children are spoken to about their experiences (paragraph 33).

2. Ensure that strategy discussions and section 47 child protection enquiries clearly describe interim protection arrangements and contingency plans (paragraphs 20, 21).

3. When cases are stepped down from statutory children's social care services, ensure that proper consideration is given to whether the family would benefit from ongoing support and that a plan is put in place where needed (paragraph 16).

4. Take steps to ensure that the progress of all investigations concerning allegations about professionals is robustly monitored until investigations are concluded and outcomes are confirmed (paragraph 38).

5. Ensure that:

    - the senior management review of all children looked after under a Section 20 arrangement is accelerated and that the permanency plans and legal status for these children are appropriate and clear (paragraph 42).

- the senior management review of all children who are subject to the pre-proceedings phase of the Public Law Outline is accelerated and that pre-proceedings work is timely for all children (paragraph 41).

6. Take action to ensure that all children who become looked after have an initial health assessment within 28 days and see a dentist at least annually (paragraph 57).

7. Ensure that, for all children who return home from care, an assessment of the child's and family's circumstances is undertaken to determine their ongoing needs (paragraph 53).

8. Include more precise and measurable attainment targets in the personal education plans of children looked after. Narrow the attainment gap between children looked after and other children in Medway across all key stages (paragraph 59).

9. Continue to improve the impact of the local education, employment and training (EET) strategy in order to achieve better outcomes for care leavers. Ensure that all 16–18-year-old young people who are looked after receive high quality EET support (paragraph 94).

10. Ensure that adoption is formally considered as a permanence option for children looked after of all ages and that there are sufficient adoptive placements for children over the age of five (paragraphs 68, 81).

11. Improve the quality of child permanence reports and later-life letters so that they contain all the information needed for children to understand their life stories in the future (paragraph 79).

12. Ensure that all staff receive regular and supportive supervision in accordance with the local authority's policy. Provide all managers with training on good practice in supervision. Ensure that case supervision is appropriately focused on progressing children's plans (paragraphs 32, 111, 112).

13. Take steps to minimise the disruption to children and their families from workforce changes. Where change is unavoidable, ensure consistency and continuity of case planning (paragraphs 32, 117).

Summary for children and young people

- Ofsted inspected children's services in Medway in 2013. Inspectors were so worried about what they found that they judged services to be inadequate for children who needed help, protection and care.
- The Medway Improvement Board, set up to make sure the right changes were made to improve the experiences of children, has done its job well. In this

inspection, inspectors found that, since 2013, managers and local politicians have done many of the things that were needed to improve services for children.

- Now, when children need urgent help or are at risk of being harmed, social workers step in quickly. Police, schools and health professionals work well with social workers to decide what to do next. Most children are helped by the right people at the right time. Managers still need to do more to make sure there is enough support for families when they first begin to find life difficult. Leaders are already thinking about how they can do this better.
- When children are at risk of being harmed, child protection plans are always written and shared with families. The plans say why professionals are worried and what needs to be done to make children safer. Managers, social workers and other professionals do not always think often enough or carefully enough about what is working and what needs to be done differently. It is very important that they put this right to improve children's lives more quickly.
- Managers make the right decisions about children coming into care. Most children who live in foster or adoptive families or in children's homes are settled, happier and doing much better than before they came into care. Decisions about where children will live for the rest of their childhood are not always written down to make sure that everyone knows the plan. Not enough looked after young people gain important qualifications such as in English and mathematics.
- Some children have had lots of changes of social workers and have found this difficult. Managers have spent more money on extra staff and are doing all they can to find more good social workers. This is beginning to make a difference.
- Social workers are well trained and care about the children they are helping. Managers and local politicians value what young people say. The Children in Care Council is a dynamic and determined group whose work is leading to changes for all children looked after. Care leavers are helping to improve services by, for example, giving their views on the quality of new housing options.
- When very young children cannot stay with their own families, social workers find them caring adoptive parents. This is beginning to happen more quickly. Social workers and managers need to find more adoptive families for older children.
- When young people leave care, personal advisors make sure they have somewhere safe to live and help them to achieve their goals. Pathway plans include the right things and are written in a language that makes sense to young people. Care leavers who have emotional difficulties need better support from the right health professionals.

The experiences and progress of children who need help and protection	**Requires improvement**
Summary Early help services are increasingly effective in identifying need and supporting	

children and families. Thresholds between early help and children's social care are clearly understood, but services are not always well coordinated. This means that some children and families, where there is no immediate risk, are not getting the help they need at an early enough stage.

The co-located, multi-agency Children's Advice and Duty Service (CADS) provides a robust response to children's needs. Thresholds are consistently applied by qualified social workers and managers. Information is shared effectively and parental consent sought. Some contacts take too long to progress while social workers decide how best to help families, who then wait too long to find out what support they will receive.

The quality of social work support for children in need, including those in need of protection, is variable. For some children, practice is decisive; plans are clear and are progressed in a timely way. However, some child in need and child protection plans are not sufficiently specific and social workers and their managers do not give enough attention to ensuring that all plans are progressed. Some multi-agency core group reviews are not held regularly enough and, on occasion, are missed altogether. As a result, some children's situations do not improve at the pace that is needed. When children no longer need help from children's social care, the plan for ongoing support is not always clear.

Children at risk of significant harm are identified effectively. Child protection strategy discussions and section 47 child protection enquiries include key professionals. Information is shared appropriately and decisive action is taken to understand and reduce harm to children. However, interim and contingency plans are not always sufficiently clear.

Risks relating to child sexual exploitation are identified and responded to well. Children and young people are helped and risks are reduced. A multi-disciplinary child sexual exploitation team is currently in development to further strengthen the quality of service. The response to children who go missing is robustly managed and missing incidents are proactively responded to. Return interviews take place when children go missing, but they do not always happen in a timely way and professionals do not consistently use the information in planning and working with children and young people.

The number of concerns about professionals working with children in Medway has risen. Most investigations are managed well by the Designated Officer, but the tracking and progression of this work are not consistently robust.

Inspection findings

14. A clear early help strategy has now been developed and implemented. This has led to a more structured delivery of local early help. It is too early to evaluate the impact of these revised arrangements, but they are based on both a comprehensive analysis of local need and learning from what works effectively elsewhere.

15. A range of early help services is available to children and their families. The common assessment framework (CAF) is increasingly effective in assisting the identification of need and promoting the coordination of work between professionals. However, services are not yet fully integrated and the accessibility and effectiveness of early help are inconsistent. This means that some children are not getting the help they need to improve their circumstances. The local authority's family support service meets the needs of families with more complex needs well and the recent expansion of the service is enabling more children to benefit from this support. However, where local authority family support workers are not directly involved in the service being provided, plans of support are less well structured. The local authority has recognised these weaknesses and has implemented clearer arrangements to improve the integration, monitoring and targeting of this work.

16. Thresholds between early help provision and statutory child protection work are clearly defined, understood and appropriately applied. In a few cases, when planning and making decisions, social care professionals are not fully considering the actual service likely to be delivered through early help. Similarly, when cases are closed by social care, consideration is not always given as to how support will continue to be provided and coordinated, leaving some families without all the support they need to maintain the progress they have made.

17. The co-located, multi-agency CADS provides a robust response to children's needs. Any professional who contacts CADS with a concern about a child is offered a conversation with a qualified social worker. This is a particular strength because it facilitates effective information sharing and is helping to support the development of a shared understanding of thresholds across the partnership. Thresholds are appropriately applied, informed by historical information, take account of parental consent and are authorised by social work qualified managers.

18. A dedicated domestic abuse social worker is located in CADS. This worker reviews all incoming police domestic abuse notifications and notifies key professionals involved with the child so that they are able to offer support where needed. It is too early to evaluate the impact of this process fully, but there is evidence that it is beginning to make a positive difference for some children. Inspectors saw several instances where, for a period during summer 2015, police had not shared low- to medium-risk domestic abuse notifications until some weeks after the incident occurred. This issue came to light during the course of the inspection and the local authority took decisive action to address this.

19. Work to progress contacts is purposeful, with a focus on providing the right support for families. However, many contacts take too long to progress. On occasion, this is due to workload and capacity, but sometimes social workers may spend a week or longer seeking information to inform and validate decisions. Children are safeguarded, but some children and families wait too long for a decision to be made about the help that they will receive. Senior managers have identified this issue and have introduced appropriate measures to review all contacts that remain in the service for over 24 hours. However, at the time of the inspection, these reviews were not taking place due to reduced senior social worker capacity.

20. The quality of strategy discussions and child protection enquiries has improved. This was an area of weakness in the previous child protection inspection. Strategy discussions are convened in good time; they identify and respond well to risk. This leads to protective action where required. Key agencies contribute well and meetings are an effective forum for information sharing. Strategy discussions do not, however, routinely set out interim protection arrangements or contingency plans.

21. Child protection enquiries are timely, outline key risk and protective factors and are overseen by managers. They do not always include a detailed rationale to support decision making and social workers do not record checks with other agencies in one consistent place. This makes it difficult for managers to assure themselves that recommendations are based on all available information. Like strategy discussions, they do not consistently include interim protective arrangements or contingency plans. Decisions about next steps are appropriate. Where there is an unresolved risk, managers take decisive action, including convening timely initial child protection conferences. As a result of a concerted effort by the local authority, considerable progress has been made in this area over recent months, with 91% of initial child protection conferences convened within statutory timescales in the year to July 2015. This is a significant improvement compared with 60% in 2014–15.

22. Almost all children are seen regularly by social workers and, where appropriate, they are seen on their own. The voice and experiences of children are increasingly evident in case recording, most of which is up to date and appropriately detailed. Examples of direct work are evident in a few children's records but, more often, social workers are better able to articulate the work they have undertaken than is reflected in their case recording.

23. Assessments are of a variable quality but there is evidence of steadily improving practice and timeliness in this area. Several assessments seen were of good quality, identifying risks and needs and including comprehensive historical and agency information. Assessments consistently reflect the voice and experiences of children, consider the individual and diverse needs of each child in the family and some are informed by research. In cases seen by inspectors, appropriate thought had been given to how long an assessment should take, based on the child's particular situation. Managers review the progress of assessments at key points. The completion of assessments, in the right timescales for individual children, is leading to their needs being identified and met at an earlier stage.

24. Child protection conferences are effective in identifying and responding to risk and are well attended by partner agencies. The 'strengthening families' model is used well in conferences. Parents and professionals find this approach helpful in identifying what is working well and what needs to change. Most plans include key actions and timescales for delivery, but some do not focus clearly enough on what needs to happen in order to make children safer. Plans include contingencies, although most are 'catch all' statements regarding seeking legal advice rather than what action will be taken if concerns increase or children's experiences do not change. This means that children, families and professionals are often not clear enough about what will happen if the risks are not reduced.

25. As at 31 March 2015, the proportion of children subject to child protection plans in Medway was higher than in similar local authorities. This is due to an increase in the number of plans from 358 in March 2014 to 474 in March 2015. Numbers have remained stable since this time. The Director of Children's Services and the Medway Improvement Board have been proactive in seeking to establish whether the right children are subject to the right plans, commissioning a number of internal audits and external reviews. All of these have concluded that thresholds are set at the correct level and this is line with what inspectors found in individual cases. The increase is considered by managers to be a result of a legacy of previous poor assessments, gaps in availability of early help services and increasingly robust management oversight of child in need plans and thresholds.

26. Neglect was a key concern for 41% of children subject to child protection plans at 31 March 2015. In assessments seen by inspectors, social workers had carefully and sensitively explored the day-to-day experiences of children living in neglectful households. The local authority, with the Medway Safeguarding Children Board (MSCB), has made tools available to assist professionals in further understanding the impact of neglect on children. However, there is little evidence within case files of the use of these tools.

27. Sexual abuse is the main category of concern for 7% of children subject to child protection plans. Domestic abuse is known to be a cause for concern for 49% of the children subject to these plans and is a contributory factor to the number of children subject to child protection plans due to neglect (41%) and emotional abuse (40%). Families experiencing domestic abuse have access to a range of support services. These include a well-utilised 'one stop shop' that provides various support options. The 'day programme' effectively supports young people who have witnessed domestic abuse and the 'domestic abuse recovery together' (DART) programme provides therapeutic intervention for parents and children. Arrangements for sharing information and coordinating support for victims of domestic abuse at multi-agency risk assessment conferences (MARAC) are effective, although consideration of the impact of the domestic abuse on the children in the family is not always fully considered.

28. A range of services is also available for those children and families experiencing difficulties due to substance misuse and mental ill health. The co-location of an adult services mental health social worker in CADS effectively integrates support for parents and children. The local authority has reviewed its commissioning arrangements. Some services have been decommissioned where they did not meet current needs or performance requirements. Others, such as CAMHS, short breaks and substance misuse services have been reviewed and are more closely monitored, resulting in improved delivery of service.

29. Child in need plans address children's needs and potential risks but are under-developed; actions are not sufficiently linked to outcomes and timescales are not always clear. While in the majority of cases seen by inspectors, regular and usually purposeful visiting was evident, this work is not routinely being driven by the plan or subject to robust review. Some cases are closed without considering continuing support to the family.

30. Increasing the effectiveness of child protection plans continues to be a priority for senior managers. This was highlighted as an area for improvement in the previous child protection inspection. Inspectors saw examples of effective practice where decisive planning and intervention were leading to improved outcomes for children, but too many plans are not robustly progressed. Managers acknowledge that although multi-agency core groups are well attended, they are not regular or effective for all children. In a few cases, practice is weak; for these children, plans do not progress in good time, risks are not sufficiently reduced, and children's situations do not change quickly enough. For example, in a small number of cases seen by inspectors, these meetings had not taken place at all. Although partner agencies consistently attend key multi-agency meetings, they do not routinely support purposeful action or escalate their concerns where plans drift or actions are not progressed.

31. Where child protection plans do not lead to sufficient improvements in children's lives, managers seek legal advice. The number of children's cases subject to the pre-proceedings phase of the Public Law Outline in Medway is high and this approach is used to step up intervention where child protection plans are not effective. In some of these cases seen by inspectors, earlier planning, intervention and review should have been more purposeful and robust.

32. Managers regularly discuss children's plans with social workers and record these discussions on case files, but management oversight is not sufficiently challenging. Decisions do not always identify how actions link to the child's plan or whether the plan is reducing risks for the child. Inspectors also saw several cases where plans had drifted due to changes in social workers or gaps in allocation. Appropriate safeguards are in place to identify and reduce practice such as this, including oversight by IROs, operational performance meetings and child protection surgeries. However, these measures have not been used consistently or effectively to identify or address shortfalls.

33. Children who go missing receive a comprehensive and responsive service. The help provided is effective in reducing the risks children face and ensuring that their support needs are met. A dedicated missing children's coordinator reviews all missing episodes and takes appropriate action to ensure that children's needs are responded to at an early stage. The coordinator also provides flexible support to professionals working with children who go missing. During the three-month period prior to the inspection, the missing service dealt with 149 incidents involving 55 children in need and 19 incidents involving 10 children subject to child protection plans. Independent return interviews are completed, but some of these interviews are outside of the required 72-hour timescale and findings are not considered consistently to inform future plans for children.

34. The coordinator for children missing education and the head of the inclusion team actively track and follow up children missing education. Robust steps are taken to identify the whereabouts of these children. Children in alternative provision are carefully monitored. The coordinator for children missing education and the head of the inclusion team work effectively with attendance officers to ensure that children attend school regularly. Close working with home-school support staff ensures that the additional needs of these children are met by specialist services such as CAMHS.

35. For those children identified as being at risk of child sexual exploitation, a proactive approach is taken to respond to need and risk at an early stage, with direct work and support undertaken where this is needed. Agencies share information effectively in order to understand risk, improve children's circumstances and prevent risks escalating. Professionals assess the risk of child sexual exploitation using a risk assessment toolkit and, where concerns are evident, clear safety plans are put in place. The local authority is planning to further strengthen services for children at risk of sexual exploitation through the creation of a co-located, multi-agency sexual exploitation service.

36. Support for young people who are vulnerable due to homelessness is consistent with the recently revised Medway joint housing and social care protocol. Between April and July 2015, all 20 young people aged 16 and 17 who presented as homeless received a joint housing assessment. Assessments seen by inspectors were of a good quality and accurately identified young people's support needs. Young people are offered mediation to help them to remain in their families where possible, although it is not always clear whether their entitlement to leaving care services has been fully explained to them. When required, appropriate housing and support are provided, with bed and breakfast accommodation used very rarely and only in the event that all other options have been exhausted. Plans are in place to strengthen this service by locating a joint-funded housing post in CADS.

37. Through persistent work, the local authority and the Medway Safeguarding Children Board have successfully raised awareness of private fostering. Consequently, the number of notifications has increased in recent years. Once notified, children are seen and spoken to promptly and thorough assessments of their care arrangements are completed in line with statutory requirements. Children who are privately fostered are visited regularly and receive high quality, sensitive support centred around their individual needs.

38. Where allegations are received regarding professionals working with children, a specialist team of social work qualified designated officers undertakes strategy discussions and investigations. The team has seen a significant increase in referrals over the last year, prompting additional investment. Despite this, management capacity has been affected. The initial response to allegations is appropriate to ensure that children are safeguarded. However, during the inspection two cases sampled by inspectors had not been effectively tracked or progressed. The oversight of referral and investigation outcomes has not been robust in all cases.

The experiences and progress of children looked after and achieving permanence	**Requires improvement**

Summary

Outcomes for children looked after are improving in Medway. The majority of children looked after live in stable placements. These enduring placements enable children to develop consistent attachments to their carers and to settle in local schools.

Social workers see children looked after regularly and know them well, including those placed at some distance from the local authority. However, care plans do not describe desired outcomes. The health needs of children looked after are regularly reviewed, but initial health assessments are not timely and too many children do not see a dentist regularly.

Permanency planning has improved since the Ofsted inspection in 2013, but some decisions about children's long-term status are not sufficiently clear. Senior managers are actively and systematically tackling this issue.

Managers track cases in the pre-proceedings phase of the PLO However, the process takes too long to progress or conclude for some children. Although these children are safeguarded, decisions about next steps are not consistently made quickly enough. When care proceedings are instigated, the timeliness of progression of children's cases to a final hearing shows significant improvement over the last year. Managers have taken steps to improve the quality and timeliness of connected persons' assessments, but these require further attention to be good.

The response to children looked after who go missing and who are at risk of sexual exploitation is well coordinated and prompt. Return interviews are held, risk assessments are undertaken and clear safety plans are developed to reduce risks.

Assessments and reviews for children looked after who return home from care do not always happen in good time and they do not consistently consider whether the original concerns and problems have been addressed.

The progress made by children looked after between the key stages in reading, writing and mathematics is below other children both in Medway and nationally. The

gap in educational achievement between looked after children and their peers is not closing quickly enough. Personal education plans are reviewed regularly and engage the right people but some targets are not precise enough to ensure that everyone is clear about what they should be working towards to support and improve children and young people's progress and achievements.

Younger children are adopted quickly and the speed of this is improving. However, not enough is being done to ensure that older children are able to live in adoptive homes quickly. Child permanence reports and later-life letters are not consistently well completed.

Services for care leavers have significantly improved and are now good. Personal advisers provide excellent practical and emotional support and use pathway planning effectively. A continued sharp focus is needed to ensure that all 16–18-year-old looked after young people receive high quality post-16 support.

Inspection findings

39. Decisions that children should become looked after are made by senior managers and, in cases seen by inspectors, these decisions were timely and appropriate. Medway has experienced a notable recent increase in the number of children looked after, with numbers rising from 380 at 31 March 2014 to 435 at the point of the inspection. The proportion of children looked after under a voluntary arrangement is high and has increased further over the last year from 40% at March 2014 to 47% in March 2015. In cases seen by inspectors where children had been recently accommodated, the use of voluntary arrangements was appropriate.

40. The family support service works effectively with families with complex problems, including some where there is a risk that children will need to be looked after. However, targeted 'edge of care' services have been slow to develop in Medway. A multi-disciplinary team was being set up at the time of the inspection, with some appointments made. This team has begun to focus on targeted prevention work with adolescents on the cusp of coming into care, alongside work with young people already in care, to achieve safe and enduring returns to their families. The evidence base for a separate service for younger children is currently being evaluated. It is too early for either of these new services to demonstrate impact.

41. A large number of children (98 from 47 families) are subject to the pre-proceedings phase of the PLO. The majority of these children have been subject to pre-proceedings planning for 16 weeks or longer and a number of children for six or nine months. Legal advice is appropriately sought, letters are sent to families outlining concerns and managers meet with parents to explain why they are concerned. Cases are overseen by senior managers using a pre-proceedings tracker. However, important pieces of work such as parenting assessments are not always undertaken in good time. Although children are safeguarded through child protection plans or through being looked after, decisions about next steps are not consistently made quickly enough. This leaves children and their carers uncertain for too long as to the local authority's plan for their future care.

42. A significant number of children accommodated under voluntary arrangements have been looked after for a considerable period of time and are in stable placements that meet their needs well. However, some children and young people who have been in care for more than two years have not had their permanent care arrangements secured through a senior management decision. In six out of 12 cases tracked by inspectors, formal permanency planning for children looked after was delayed. Sequential, rather than parallel, planning was evident for some babies and infants in care proceedings, resulting in avoidable delays in permanency planning at an early stage. Managers have identified the need for improved practice in this area and are systematically reviewing plans for all children looked after to determine if care proceedings should be instigated or whether their arrangements should be formally approved as long-term fostering placements.

43. Thirteen children left care under a special guardianship order (SGO) in the six months prior to the inspection. In the same period, nine children left care through child arrangement orders. This performance is comparable with other local authorities and demonstrates that social workers and managers are considering a range of permanence options for children. However, in two out of five cases sampled by inspectors where foster or family carers were applying for an SGO, progress was delayed due to carers' uncertainty about continuing financial support. Timely progress of SGO assessments was more evident where children were subject to care proceedings. Assessments for children living with connected people such as friends or family members are not always completed quickly enough and in two cases seen by inspectors, managers had not authorised emergency arrangements at an early enough stage.

44. For children and young people who enter care proceedings, both the timeliness of the process and the quality of social workers' evidence has improved considerably. This progress has been endorsed by Cafcass and the Family Justice Board (FJB). The length of care proceedings has reduced from 44 weeks in 2014 to an average of 32 weeks. While this remains above the target of 26 weeks, the trend is positive. Cafcass and the FJB report regular and constructive senior management engagement, joint training and improved compliance with court timescales and directions. This is contributing to an improving standard of evidence in court statements and care plans, and to the timeliness of court proceedings.

45. The majority of children looked after are allocated to the long-term looked after and proceedings service. This allows social workers to form relationships with children from the early stages of being looked after and reduces service-led changes of staff. Service remodelling, although initially disruptive to social work relationships, has led to the majority of children who have been looked after for more than 12 months experiencing a consistent social work relationship for at least six months.

46. Social workers' caseloads in the long-term team have reduced recently and, as a result, workloads are more manageable – at an average of 18 to 20 children. Social workers appreciate the readily available support and supervision provided by team managers. Regular management oversight is evident in the vast majority of cases, although reflective discussion is less evident.

47. The large majority of children looked after are visited and seen alone by social workers at least every six weeks, including those living in distant placements. This is the minimum standard managers have set for any child looked after to be visited, although social workers visit children more frequently according to their needs. Social workers know children well and carefully record their views and concerns. The majority of children looked after live in stable placements with considerably fewer moving three times or more each year than in other local authorities. These enduring placements enable children to develop consistent attachments to their carers and to settle in local schools. This increases their resilience and emotional health and well-being.

48. Regularly updated assessments ensure that the changing needs of the majority of children looked after are understood. Assessments are holistic, with risks, needs and protective factors clearly documented. However, care plans are not meaningful documents for children or their carers, with only a few featuring discernible outcomes or ambitions to stretch attainment and achievements. Social workers' contact with children is regular, but is not routinely and clearly guided by purposeful direct work to address the objectives laid out in care plans.

49. Overall, diversity and difference are well considered in work with children looked after. In cases seen by inspectors, the needs of disabled children who are looked after were understood well and placements are meeting their needs. In four of five cases, planning for these children was well focused on their complex needs with clear plans in place for their permanent care. Packages of care were well coordinated and extensive, reviewed through detailed looked after reviews. For children and parents whose first language is not English, careful use of translators and interpreters informs direct work. Foster carers and adopters promote positive cultural identities. Diversity is well addressed in looked after reviews and court care plans. One social worker took careful account of a black young person's feelings and wishes in identifying a new placement where she would feel more culturally connected to her carers. The young person has moved and is happier as a result.

50. Almost all reviews of children looked after are held within statutory timescales, with performance improving from 84% to 99% in the past six months. The large majority (92%), of children looked after participate in their reviews. Minutes of reviews are detailed with concise and specific recommendations and these are proactively followed up by IROs. Some review minutes provide a vibrant picture of children's personalities and achievements. However, recommendations are not consistently linked to overarching outcomes, particularly relating to plans for permanence. This makes it difficult to align actions with clear objectives to improve children's well-being and attainment.

51. IROs had not challenged delayed permanency plans with consistent rigour in a small minority of cases seen by inspectors. The IRO annual report does not provide an evaluation of the number, content and outcome of escalations and their impact on improving practice. The IRO service is predominantly comprised of locums and, although most have worked for Medway for some time, this workforce profile does not ensure long-term continuity for children looked after.

52. The advocacy service is supporting 27 children looked after, including 21 who have been referred since April 2015. Young people say they receive helpful support. Effective communication between the local authority and the commissioned service ensures that the service continues to meet their needs.

53. A very low proportion (3%) of children who cease to be looked after subsequently return to be looked after, which is positive. However, where children do return home from care, careful, informed assessments and plans are not consistently evident. In three out of five cases seen by inspectors, children returned home without either a looked after review or a child in need planning meeting. In these cases, the concerns that led to children becoming looked after had not been thoroughly assessed or addressed. Although, in cases seen by inspectors, children continue to receive support through a child in need plan and package of support, families do not consistently receive sufficient help to prevent problems from re-emerging.

54. Children looked after who go missing are carefully monitored and offered support. From June to August 2015, 34 (8%) looked after children went missing a total of 128 times; 19 children looked after had been missing on three or more occasions. The missing persons coordinator collates intelligence and analyses patterns to identify concerns about individual children and the potential risks to others. Cases seen by inspectors were well managed and return interviews were consistently completed by the missing persons coordinator. Interviews appropriately inform subsequent risk assessments and safety plans. Inspectors saw three cases where good care and support to children have led to a significant reduction in their missing behaviour.

55. Children looked after at risk of sexual exploitation are effectively identified. Child sexual exploitation assessments and safety plans are consistently completed. Risk-reduction interventions with young people living in distant placements are equally robust. Inspectors saw examples of risks being well managed and reduced for young people who had long histories of severe and persistent sexual exploitation. In two cases, secure accommodation had been used appropriately to safeguard and assess young people while further plans were made for their care.

56. Through a recent needs analysis, Medway has recognised that not enough children looked after have access to the emotional health and well-being services and support they need. Approximately a quarter of children looked after receive this support and managers acknowledge that this is not good enough. This is particularly important in light of the higher 'strength and difficulties questionnaire' (SDQ) scores (a measure of psychological well-being) for children in Medway compared to children in other local authorities. Additional investment from the Clinical Commissioning Group (CCG) has been secured and a commissioning strategy has been prepared. This is intended to reshape and increase access to CAMHS and emotional health and well-being services for children looked after, from 2016.

57. A high proportion (97%) of children looked after have their health needs regularly and comprehensively reviewed. The large majority of looked after young people approaching transition to the leaving care service are provided with an informative summary of their health histories. However, timeliness of initial health assessments for children who become looked after has been poor for a considerable period of time. Performance, linked to insufficient capacity within the looked after children's health service, remains well below the local authority's own target. This leads to delays in ensuring that children's initial health needs are promptly assessed and addressed. A quarter of children looked after do not have an annual dental appointment.

58. Offending rates for children looked after in Medway are similar to the national average. The youth offending service and police undertake effective work to divert young people from receiving criminal sanctions. This is underpinned by an innovative joint protocol between the local authority and the police. The protocol was generated by the council's corporate parenting board to reduce avoidable criminalisation of looked after young people.

59. Children looked after are not achieving as well as other Medway children or children looked after nationally. For example, in 2014/15, seven of 20 young people gained a minimum of five A*–C GCSEs, including English and mathematics and this number was lower than children looked after nationally and for all Medway children in this Year 11 cohort. The progress children looked after make between the key stages in reading, writing and mathematics is also worse on average than all children looked after nationally and slightly lower than other children in Medway. Children looked after who have special educational needs do not achieve as well as similar children in Medway. Although the local authority reports that 90% of children looked after are making progress in line with their attainments targets, the gap in educational achievement between children looked after and their peers is not closing quickly enough.

60. Pupil premium and additional funding are appropriately focused on enhancing the educational attainment of children looked after. Very specific help is provided to support the development of self-confidence and emotional and mental resilience through, for example, counselling, play therapy and additional music lessons. The head of the virtual school effectively oversees the targeting of this resource.

61. All children looked after of school age have an up-to-date personal education plan (PEP). PEPs include an appropriate level of detail and information about each young person's background. However, the academic targets are not sufficiently precise in all cases.

62. In 2014/15, the average attendance of the 319 school-aged children looked after up to the end of Key Stage 4 was 97%. This is higher than both national and local performance. This demonstrates the strong partnership between schools, the virtual school and the attendance advisory service. In 2014/15, there were no permanent exclusions of children looked after, reflecting the close working between the inclusion team and schools. The proportion of pupils with a fixed-term exclusion was 5%, which is below the national figure. Two children looked after attend a pupil referral unit. All children looked after whose health needs do not prevent them from engaging receive a minimum of 25 hours education per week. Children with significant health needs are effectively overseen by the inclusion team.

63. The head of the virtual school and head of the inclusion team monitor the destinations of Year 11 pupils effectively. Transition arrangements for children looked after with the local college and other post-16 providers are good, with timely and appropriate sharing of information. In 2015, 75% of children looked after made a positive transition into education or training with a post-16 provider or school sixth form.

64. The children in care council commendably engages with a wide group of children looked after and young people. A junior branch of the council has 69 members. Members of the children in care council collaborate well with the corporate parenting board and influence its priorities, particularly in reducing changes of social workers and setting clear, basic requirements for social workers in their day-to-day work.

65. Social workers visit children looked after who are placed more than 20 miles from its borders as frequently as those living closer to home. These children constitute 16% of all children looked after by Medway; this figure is marginally higher than similar authorities as at 31 March 2014. Access to advocacy services is equitable. Frequent changes of residential placements were also evident for a small cohort of young people with multiple and difficult needs.

66. There are not enough in-house foster carers to meet demand and the number of children placed in independent provider placements has increased. This means that it is not always possible for brothers and sisters to be placed together. Senior managers have identified this issue and an improvement plan has recently been put in place. However, the target to recruit a net gain of 10 carers over the year is insufficient to meet need. Foster carers spoken to were unclear about the relationship between payments, the skills of foster carers and the needs of children.

67. The recruitment of foster carers is robust. Appropriate checks are carried out and assessments are thorough. The fostering panel scrutinises applications and challenges these appropriately.

The graded judgement for adoption performance is that it requires improvement

68. Where children cannot live within their own families, social workers and managers appropriately consider other permanence options for them. This includes adoption. However, these discussions do not consistently take place at or before children's second looked after review.

69. Senior managers have introduced a permanence planning monitoring panel to improve their oversight of plans for children's long-term and permanent care. This panel considers a number of children of various ages at each meeting and some meetings are themed – for example, to concentrate on children who are voluntarily accommodated under section 20 of the Children Act 1989. However, the panel is not consistently attended by the full range of professionals set out in its terms of reference and decisions do not include clear timescales. For example, representatives from the adoption team do not always attend. This reduces the robustness of the panel's scrutiny and its effectiveness in driving permanence plans for all children.

70. National adoption figures for 2014–15 show that 50 children in Medway left care through adoption, a quarter of those who left care overall. This is strong performance. Numbers being adopted remain positive, although have fallen more recently, with 28 children adopted between September 2014 and August 2015.

71. Recent adoption performance has improved when compared with the three-year average adoption scorecard figures. During 2011–14 Medway, on average, took 728 days to place children with adopters after they came into care. This is six months longer than the national threshold. However, for the 28 children adopted since September 2014, this figure improved to 554 days, against a target of 487 days.

72. For those children placed for adoption in the 12 months to the end of September 2015 (seven of whom have subsequently been adopted), performance against the adoption scorecard is much improved. The government target for the time from becoming looked after to being placed with prospective adopters is met for these children.

73. For 2011–14, the figure for the time from gaining court agreement to adoption and deciding on a match with adopters was 243 days, three months outside the target. Performance in this area has also improved over the past 12 months and the government target has been met. Those placed include black, minority ethnic and disabled children. However, a very low number of children aged five or over has been placed for adoption during this time.

74. The numbers of black, minority ethnic and disabled children who were adopted is in line with the overall children looked after population. In most cases, brothers and sisters are placed together for adoption (nine out of 10 during 2014–15). A number of children over five have been adopted during this period, but, on average, it took three and a half years for an adoptive placement to be found for them. This is too long for these children to have waited. All of the 12 children for whom the local authority is currently family-finding are aged five or under.

75. Family-finding for younger children is robust, with a good range of approaches used to identify the right adopters for children. This includes the use of adoption activity days and the adoption register.

76. When children are placed for adoption, in most cases adoption orders are made suitably quickly. In a small number of cases seen by inspectors, children had been in adoptive placements for a considerable time without being formally adopted. Appropriate action had not been taken to progress this or to consider an alternative permanence plan.

77. Where plans for children to be adopted are changed, action to secure alternative permanent options for them is not always sufficiently focused or timely. In particular, there are significant delays in discharging placement orders. This means that even where these children have lived for a long time with their foster carers, they cannot be sure that the arrangements for them are permanent.

78. The quality of child permanence reports (CPRs) presented to the adoption panel is improving, but is not yet consistently good. CPRs do not always provide a sufficiently clear picture of their birth parents and siblings that children can refer back to in the future.

79. Where life story information is provided, this can be high quality, giving a child-friendly, child-focused overview of the events leading to adoption which will be helpful to children and adopters. Later-life letters contain a range of useful information, but are not always written in language that will be easy for young people to understand in adolescence, particularly in their use of jargon. Not all children being adopted benefit from life story information and later-life letters.

80. The agency decision-maker (ADM) is flexible in making time available to consider proposals for children to be placed for adoption. He scrutinises the proposals and the recommendations of the adoption panel in good time. However, the depth of the recording of the reasons supporting decisions is not sufficiently thorough. Senior managers are aware these records need to be strengthened because the chair of the adoption panel has formally raised this with them.

81. Although recruitment and approval of prospective adopters for children under five are successful, this is not the case for older children. Currently there are no carers approved for children over five. The local authority does not have any prospective adopters approved for fostering-to-adopt placements.

82. The process for approving adopters is robust. There are some delays in completing stage one of the process, but the assessment stage is consistently completed within the statutory timescales. Reasons for delay are scrutinised by the adoption panel and minutes note how long approvals have taken.

83. The adoption panel is appropriately constituted and meets regularly. The minutes show that there is challenge and debate within panel meetings, including consideration of the appropriateness of adoption support plans. The chair produces six-monthly reports that provide a suitably detailed and robust review of the work undertaken and present appropriate challenge to the local authority.

84. Adoption support plans which have been agreed with managers and adopters are generally thorough and identify the key needs of children in terms of their health and education needs, children's future contact with their birth families and the future financial support of the placement. However, delays in agreeing adoption supports plans have resulted in some children who have been placed with adopters for some time not being adopted quickly enough.

85. Adoption breakdowns are very rare. There is a range of helpful post-adoption support on offer and 19 families were receiving support at the time of the inspection. This includes support groups, financial provision, and therapeutic support (funded through the Adoption Support Fund). The adoption team oversees over 200 'letterbox' contact arrangements between adopted children and their birth families.

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

86. The experiences and progress of care leavers are good. All the relevant recommendations from the 2013 inspection of services for children looked after and care leavers have been addressed. The quality of support for care leavers has improved significantly from the poor level found by that inspection. Care leavers benefit from high-quality individual support from their personal advisers. From often low starting points, they make considerable progress towards being able to live as independent adults.

87. The leaving care team is stable and highly motivated. Team members bring a broad range of skills and experience to their work with young people. The team manager provides strong and supportive leadership and the team receives regular, good-quality supervision.

88. Pathway planning is robust and all care leavers have a comprehensive plan that is regularly reviewed and updated. This includes disabled care leavers transferring into adult social care who receive good quality support and strong advocacy from their personal advisers. Most young people have a needs assessment and pathway plan at an appropriately early stage. Plans are used well by workers to inform young people's preparation for adulthood and leaving care. For a small number of looked after young people, pathway planning does not begin soon enough. The local authority has a plan to improve services by ensuring that all relevant 16-year-olds are allocated a personal adviser to work alongside their social worker to ensure a smooth and planned transition into leaving care services.

89. Arrangements are now in place to provide young people with their health histories when they leave care although previously, care leavers have not benefited from these. A specialist nurse for care leavers provides support to individual care leavers and helps them to access other health services, including sexual health and relationship counselling and advice for young parents. This is reaching a significant number of care leavers who value the services the nurse provides to them. A range of other services is available to offer counselling support to care leavers, and in cases seen by inspectors, young people were receiving creative packages of support to meet their emotional needs. Provision for care leavers with complex mental health needs is less well developed.

90. Effective pathway planning, combined with practical and emotional support from personal advisers and housing support services, helps care leavers to develop independence skills and independent thinking. As a result, many are ready and able to live independently and successfully take on their own tenancies. The local authority has a plan to improve support by offering a drop-in centre, which will also be able to provide group work to help develop live skills.

91. Looked after children are encouraged to remain looked after until they are 18 and supported to 'stay put' with their foster carers beyond their 18th birthdays. In both these areas, local performance significantly exceeds the national average. The leaving care service is currently in contact with all its care leavers and works tenaciously to maintain links and relationships though often turbulent periods in young people's lives. Care leavers spoken to during the inspection said they felt safe and supported. When care leavers go missing, they are carefully monitored and responded to with appropriate seriousness. Personal advisers and other support services provide sensitive individual work to help care leavers keep themselves safe.

92. Care leavers live in suitable accommodation that meets their needs well. There is a reasonable range of supported accommodation, which includes some high-quality provision. The local authority has identified a need for more tailored accommodation for care leavers with complex support needs; new provision has recently been commissioned.

93. No young people were in bed and breakfast accommodation at the time of the inspection and its use is extremely rare. Some young people live in houses of multiple occupancy but only when this meets their needs. In all such cases seen by inspectors, good-quality support was being provided. When ready, care leavers are enabled to access their own tenancies and receive good tenancy support. Fifteen care leavers were in custody at the time of the inspection. This is linked to higher numbers of care leavers becoming looked after when older (post 16), when offending behaviour had already become well established. Examples were seen of very effective individual work to reduce the risk of incarceration. These young people are receiving steadfast support from their personal advisers. Careful thought is given to ensuring that young people are well supported and make good choices after their release.

94. Care leavers are offered a range of good-quality support to assist them into education, employment or training including mentoring, strong links with local colleges and universities and support developing employability and interview skills. An increasing number are also now accessing higher education (12 at the time of the inspection) and good-quality apprenticeships, including some provided by the local authority. Despite this wide range of activity however, overall outcomes remain low, with too many care leavers and 16–18-year-old looked after young people not in education, employment or training (NEET). As of August 2015, 43% of care leavers were in education, employment or training. This is partly due to previously poor looked after and leaving care services. Overall, NEET levels for care leavers are higher than for other young people in this age group in Medway, although in line with national figures for care leavers. The local authority and its partners have already identified this as a priority and continued, focused attention is needed in order to improve the impact of work in this area. In particular sustained work is required to ensure 16–18-year-old young people receive good-quality planning and targeted support to enable them to remain in education or move into suitable training or employment.

95. Personal advisers provide good advice to care leavers about their entitlements, and commitments to care leavers are included in the council's pledge to children in care. Councillors and the Lead Member for children's services are proactive in championing the cause and care leavers' views. A recent comprehensive scrutiny report has been instrumental in helping to drive further improvements to the service. However, while members of the Children in Care Council were extremely positive about the quality of personal advisers, care leavers spoken to were not fully convinced that senior managers were promoting their interests.

96. Care leavers' achievements are recognised individually and corporately. A group of care leavers have been well supported by participation workers to give their views on current services and influence service development and their views are making a difference. They have, for example, been active in visiting and evaluating potential new supportive accommodation.

Leadership, management and governance	Requires improvement

Summary

Under the firm leadership of the DCS, Medway children's services have, overall, made significant progress in almost all of the areas of concern identified in the Ofsted inspections of 2013. This has taken some time due to the need to make structural changes and difficulties in recruiting permanent managers and frontline social work staff. Some developments are at an early stage. Most areas of social work practice, including formal permanence planning for children looked after of all ages, require further improvement. A few, such as ensuring core groups are held on time and are effective for all children, need sustained attention from senior managers in order to improve practice. The very large majority of care leavers now receive good help and support, although sustained attention is required to improve education, training and employment outcomes.

Elected members have actively monitored and supported the improvements, in particular through stronger corporate parenting and injections of additional funding, leading to a significant increase in the establishment of social work posts. A variety of strategic groups, including the Medway Improvement Board, has worked effectively to develop and improve services to children. Partnerships with other agencies have been strengthened through greater collaboration, joint working and joint commissioning of services.

Robust quality assurance, audit and performance management systems have been implemented to inform the development of services and monitor the work undertaken. These measures have ensured that senior managers have an accurate understanding of the strengths and weaknesses within services. Where further improvement is needed, such as in the number of foster carers and adopters available, plans are in place to address this. However, first line managers do not consistently use the information available to them to ensure that core social work tasks, such as connected persons' assessments, are completed well and in good time. Although management oversight is clearly evident on case files, it is not always effective in driving or challenging plans for children. Managers do not consistently provide staff with supervision at the right standard.

A range of creative recruitment and retention initiatives has been introduced. These initiatives have been effective in recruiting a permanent senior management team, which has systematically tackled most areas that required improvement. Recruitment of sufficient first line managers and social workers remains a challenge, with continued over-reliance on agency staff to fill newly created posts. This has negatively impacted on the consistency and continuity of practice for children, some of whom have continued to experience too many changes of social worker. Although all cases were allocated at the time of this inspection, some children have experienced periods without a consistent named social worker to progress their

plans.

Newly qualified social workers are well supported and the local authority has pioneered the development of the Social Work Academy in order to support social workers and managers at all points in their development.

Inspection findings

97. The local authority has gradually and systematically tackled all the issues that were raised in Ofsted inspections of child protection and children looked after services undertaken in 2013. In almost all areas, there has been marked improvement as a result of decisive and directive strategic management and leadership, combined with robust monitoring by elected members and external and internal improvement boards. Some areas have been successfully addressed, such as the implementation of thresholds and the development of robust contact, referral and assessment services. Most others remain work in progress, in particular those targeted at improving the consistency of social work practice and the effectiveness of management oversight in progressing children's plans.

98. The progress of change has been impeded by the significant range of organisational and staffing issues requiring improvement, combined with the challenge of recruiting capable additional or replacement social work and managerial staff.

99. The local authority knows itself well. Internal and external reviews, complaints, audits and needs analyses are used effectively to develop a realistic understanding of issues affecting children and their families in the area, and of the impact of local services to support them. For example, ongoing high levels of child protection activity have prompted internal and MIB case audits. Through this work, senior managers and partners have been able to satisfy themselves that thresholds are set at the appropriate level. Intelligence is consistently used to inform and update specific and measurable strategic improvement plans.

100. The local authority now appropriately prioritises children's services and this is reflected in its commitment of resources and oversight following the last Ofsted inspection. Elected members and senior officers are committed to ensuring that children's issues are prominent and this is now one of the council's four priorities. Significant additional funding has been allocated to the service at a time of severe constraints on council expenditure. The Lead Member for children's services demonstrates a strong commitment to vulnerable children and is instrumental in ensuring that young people, including those who are looked after, have a strong voice within the council.

101. Within the local authority's children's services, a strong senior management team has a clear sense of direction. The team is provided with firm leadership by the DCS, who maintains a direct link to the front line through meeting regularly with social workers, auditing and observing practice. At the time of this inspection, the test of assurance for the wider role of the Director was being updated.

102. Governance arrangements are clear between elected members, the council's Chief Executive, the DCS and strategic groups overseeing the development of children's services. A range of groups undertakes this function, including the Medway Improvement Board, the Medway Safeguarding Children Board (MSCB), an internal improvement board, the Health and Wellbeing Board and the Children's Action Network. Their respective work programmes are closely aligned with crossover in some of the membership. There is little duplication and lines of accountability and networking are transparent.

103. The Corporate Parenting Board is an active advocate and scrutineer of services for children looked after. Its four sub-groups on youth justice, housing, health and education reflect the right strategic priorities, regularly reporting to the board on their progress. The board's priorities and business plan align with strategic priorities for children looked after and the improvement plan. The board closely interrogates the children looked after performance dashboard. A recent focus has been on improving services for care leavers, in particular supported housing provision. Engagement between the board and the Children in Care Council is well developed and is valued by both. Governance arrangements are well established, particularly in relation to the role of the Children's Overview and Scrutiny Committee. The board has secured three apprenticeships for care leavers in the council and is working to increase numbers further. The board has led on the production of a creative joint protocol with Kent Police to avoid unnecessary criminalisation of children looked after. The board is particularly active in foster carer recruitment campaigns and monitors social work caseloads. Further work is needed to challenge and improve performance relating to the number of children looked after who have a timely initial health assessment.

104. Robust quality assurance processes are now well established and these are closely aligned with the quality assurance processes of the MSCB. A range of case audit and themed audits is undertaken, which is closely moderated to ensure consistency and accurate benchmarking. The chair of the improvement board is directly involved in case auditing. Managers routinely re-visit audits to ensure that learning and actions are progressed. The quality and consistency of these audits has been improved in recent months and those undertaken for this inspection were rigorous overall.

105. Learning and analysis from audit and quality assurance processes are regularly reported to key strategic groups, such as the senior management group, the improvement boards and the MSCB. They are used well to identify areas of strength and areas that need to be addressed. Managers apply this learning to promote staff development. Quality assurance processes are closely aligned with an extensive range of performance management information, which is routinely and regularly collated.

106. Through learning audits and targeted training, the local authority has taken appropriate steps to address poor practice. For example, poor timeliness and quality in the completion of connected persons' assessments has resulted in procedures being updated and targeted practitioner workshops, although work is not yet of a sufficient quality. The training offer is comprehensive and social workers report that they are encouraged and enabled to attend. Average social work caseloads are reducing, at around 22 but some remain too high, at around 30. Social workers spoken to by inspectors said they were well supported and managed. Most could articulate where practice still needs to improve and were confident in the actions of senior managers to continue to improve services.

107. Senior managers acknowledge that despite comprehensive staff training, targeted coaching and the introduction of a range of new systems and tracking tools, some areas of core social work practice have been stubbornly slow to improve. Senior managers are keenly aware that there are not enough permanent, experienced first line managers to drive improvement in all areas. For example, sustained operational involvement of skilled managers is required to improve the timeliness and effectiveness of pre-proceedings work. Achieving stability and consistency at this level is being afforded the right attention by senior and political leaders.

108. Performance management information and analysis have significantly improved since the last inspections and have been developed in conjunction with other authorities across the South East. This has been strengthened in response to the requirements of the local authority's children's senior management group, the improvement boards, the MSCB and elected members who regularly receive and interrogate performance reports and who have decided the areas that require monitoring. Performance information is systematically analysed and reported to operational managers across children's services, to enable them to monitor and manage their services and staff. Weekly service performance meetings are held within the teams with analysts, to assist team mangers to manage their teams. However, team managers do not consistently maximise the use of performance information available to them and this limits their effectiveness in quality assuring and progressing the work of their teams.

109. Commissioning of services to support children and their families has improved significantly since the last Ofsted inspection. Additional capacity has enabled commissioning staff to systematically review and implement more robust performance monitoring of services. Extensive needs analyses have been undertaken across a range of service areas, in particular for children looked after and for the development of early help services. These analyses have informed the development of new commissioning plans and frameworks for the reconfiguration of services. Most of these are scheduled to be implemented in the latter part of 2015, so it is too early to assess their impact. In the interim, existing commissioned services have been reviewed and a few have been decommissioned where they did not meet current needs or performance requirements. Others, such as CAMHS, short breaks and substance misuse services have been reviewed and more closely monitored, resulting in improving service delivery. Joint commissioning has significantly improved through the establishment of the joint partnership commissioning team between the local authority and the Clinical Commissioning Group.

110. Relationships between children's services and key partner agencies have been strengthened significantly in recent years, with improved collaboration, communication and engagement, facilitated by the DCS and the senior management team. For example, Cafcass and the judiciary report positive relationships and networking with managers and staff within the children's services, and a real drive from senior managers to engage with Cafcass and the courts through active participation in the FJB. This has resulted in closer monitoring of cases going through the courts and significant improvement in the timeliness of this work. However, Cafcass and the judiciary report ongoing concerns about the impact of changes of social worker on the consistency and quality of practice. Cafcass and health services report working closely with the local authority children's services, providing induction for newly qualified social workers and workshops to increase social workers' understanding of the role of key issues affecting families, such as neglect.

111. Senior managers have focused on improving the oversight and direction by first line managers on individual cases and this has significantly improved since the last Ofsted inspection. Most cases seen by inspectors did contain operational management decisions and actions required and some also included reflective discussion. However, too many cases did not demonstrate consistent or continuous management oversight to drive forward case planning. In particular, managers do not ensure that all child protection plans are progressed through regular and effective core groups, or that permanence plans are formalised and driven for children of all ages.

112. Inspectors reviewed 30 personal supervision files for social workers and managers across children's services. Of these, 26 were not of an adequate standard and did not meet the standards set by the council's own supervision policy or follow supervision agreements made with staff. Regular supervision was not evidenced and in almost all, there were significant gaps or no records or explanation provided. Despite 65% of team managers attending supervision training in February, May and June 2015, almost all recording was of a poor quality, with little evidence that issues arising from previous supervision sessions were carried forward for discussion at subsequent meetings. None evidenced reflective supervision.

113. The recruitment and retention of competent staff within children's services remain a key challenge. A wide range of initiatives has been developed and implemented to reflect market forces and attract appropriate staff. New staff are subject to a rigorous interview process, which includes a number of exercises to test their practice skills. Probationary processes are robust.

114. High use of agency staff continues to adversely affect the stability of social work relationships with children and families and the local authority's ability to achieve consistency of practice. As at 31 May 2015, 27 of the social workers within core social work teams were from an agency. However, this is in the context of a 62% increase in the social worker establishment in the past two years (54 posts). Many of the new posts are initially filled with agency social workers while managers seek to recruit further permanent staff. During the past two years, 75 permanent social work appointments have been made, a testament to the increasingly robust recruitment and retention arrangements. These new social workers have either been appointed to the additional posts or have replaced other permanent or temporary staff who have left the local authority. Turnover and sickness rates are in line with similar authorities.

115. The local authority has successfully secured a stable permanent senior management team. However, one of the key barriers to achieving greater consistency in practice is the high number of agency first line managers. This rose from 14 out of 24 in April 2014 (58%) to 17 out of 26 in June 2015 (65%). Recruitment of first line managers continues to be a significant challenge. Many have been 'home grown', promoted from among social work staff. Managers seen were all enthusiastic about managing and developing their service, while realistic about the key issues faced. In particular, the variability in the quality of work undertaken, exacerbated by staff turnover or changes. The local authority understands how crucial first line managers are to achieving greater consistency in social work practice and as a result, has developed an 'assessed year in management' programme to develop the management skills of experienced and talented social workers. This is due to be launched early in 2016. It is an appropriate response to the shortfall in team managers but the initiative has taken too long to put into place.

116. The combination of the increase in the overall social work staff complement, staff turnover and high use of agency staff has led to a significant number of staff changes over time. Some social workers and managers have also changed roles as a result of promotion or structural changes in teams and services. While this has some positive benefits in developing and improving the quality and stability of services overall, many children and young people have experienced too many changes of worker, limiting their ability to form trusting relationships and reducing continuity of support and case planning.

117. The vulnerability of the local authority's staffing position is illustrated by the difficulties they experienced earlier this year in responding to an unexpected shortage of agency staff. This resulted in a period where a number of cases were overseen by managers and held on duty while waiting for newly appointed staff to take up their posts. Sampling of these cases indicated that the majority were closely overseen by managers during this period and that there was limited negative impact on children's experiences. However, in a small minority of cases this led to significant delay in plans being progressed. All cases were allocated at the time of this inspection.

118. The children's principal social worker (PSW) is making a significant contribution to understanding and improving social work practice in Medway. Separate post holders for adults and children work closely together to integrate and improve practice. The PSW co-chairs the Social Work Academy Board, and has a key role in evaluating its impact. Links with local universities are mutually beneficial and provide free training courses for Medway staff; this demonstrates partnership working and a commitment to best value. Along with the Advanced Practitioner, the PSW undertakes learning audits, and ensures that learning is effectively disseminated through a variety of approaches including one-to-one coaching and mentoring, workshops and briefings. Themes include court report writing and undertaking child sexual exploitation risk assessments. The PSW has undertaken home office accredited anti-radicalisation Prevent training. She has been proactive in ensuring that children's service are fully engaged with the local multi-agency Prevent and Channel processes, which aim to safeguard vulnerable people from being drawn into violent extremist or terrorist behaviour. She is helping social workers to understand how to identify children at risk of radicalisation and extremism.

119. The Medway Social Work Academy, set up in 2014, is an ambitious and innovative project. It provides a wide range of professional development support and opportunities for social workers at all stages in their professional development, including those wishing to return to the profession. The academy is nationally recognised, having supported large numbers of social workers and students in the past 10 months. Newly qualified social workers (NQSWs) in their assessed year in employment (ASYE) are supported well by the academy. At the time of the inspection, 17 NQSWs were employed within children's services, with a further cohort of seven due to start in January 2016. The programme is well structured and organised.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement to be good

Executive summary

This executive summary should be read alongside the recommendations in the next section of this report. Each recommendation is clearly linked to the relevant paragraph(s) that set out the detailed findings of this inspection.

The Medway Safeguarding Children Board (MSCB) has made significant progress during the last six months and now benefits from strong independent leadership.

It has responded promptly and positively to a diagnostic undertaken by the Local Government Association in February 2015, which enabled partners to gain a clear understanding of its strengths and areas for development.

Until recently, the MSCB has not systematically demonstrated active challenge. In March 2015, the Board introduced a challenge log that has encouraged partners to better evidence constructive challenge.

The Board has established clear governance arrangements with its partners and with other key strategic groups that oversee work with children and their families. The MSCB has reviewed its sub committees and working groups. These are now better aligned to the Board's priorities and link well together, although the work programmes for some groups are too broad. Attendance at some groups has not been sufficiently consistent over the past 12 months and the chair has engaged with partners to improve attendance.

The Board receives a wide range of performance information from its partners. However, this is too broad and not sufficiently focused on its key priorities. For example, it has not enabled the Board to identify whether core groups effectively progress child protection plans.

The Board has begun to involve young people in developing its work. Although this is at an early stage, these young people are keen to develop their role further.

The changes in business support staff experienced by the Board in recent years have negatively impacted on its work. During 2015, the team has stabilised. Permanent appointments and a redistribution of roles are beginning to better support its work.

The Board has effectively overseen the coordination of support to vulnerable groups, in particular missing children and those at risk of sexual exploitation or domestic abuse.

The Board has ensured that partners report how they ensure that children are

safeguarded through their safeguarding audits and school reports, although it has not sufficiently ensured that information from these has been systematically collated.

A wide range of multi-agency safeguarding training is provided and is well attended by workers from most agencies, although attempts to evaluate the longer-term impact of training have had a poor response.

Recommendations

120. Implement the restructuring of MSCB sub-committees and working groups and ensure that their work is proportional and manageable (paragraph 128).

121. Scrutinise the effectiveness of multi-agency child protection work, particularly in relation to the frequency and effectiveness of child protection core groups and the progression of child protection plans (paragraph 129).

122. Develop rigorous methods to evaluate the impact of the work of the Board and its multi-agency training and ensure that partners engage in this evaluation to enable effective multi-agency practice (paragraph 138).

123. Renew the MSCB's oversight of safeguarding policy and practice across its partner agencies, through safeguarding and school audits, and rigorously collate and address findings from these (paragraph 128).

Inspection findings – the Local Safeguarding Children Board

124. Joint working protocols between the Medway Safeguarding Children Board (MSCB), the Health and Wellbeing Board, the Community Safety Partnership, Safeguarding Adults Board and the Children's Action Network are well established and ensure that safeguarding is a cross-cutting theme in their respective strategic plans. The Board is closely involved in the work of the Medway Improvement Board (MIB) to ensure that their respective roles are well synchronised and to avoid unnecessary duplication. Senior partners have begun to consider how the Board can prepare for the transition should the MIB no longer be required.

125. The independent chair of the MSCB, appointed in January 2015, has taken positive action to galvanise partners to secure their commitment, enthusiasm and engagement in the work of the Board. The chair is well respected by partners and is well supported by the council's Chief Executive, DCS and Lead Member. The chair has developed strong communication with Board members, with the DCS and with the chair of the MIB to promote a common and realistic understanding of how effectively local children are safeguarded. The Board has responded positively to learning from inspections, national and local reviews and commissioned audits to improve the function and profile of the Board.

126. The DCS commissioned a Local Government Association (LGA) diagnostic of the effectiveness and impact of the MSCB in February 2015. Reporting in June 2015, it provided a rigorous and accurate assessment of the functions and effectiveness of the Board, with clear recommendations for improvement. This has been invaluable to the Board in understanding and rectifying key deficits. The MSCB has responded positively and promptly, developing an action plan to address the issues raised. Therefore, these do not form recommendations from this inspection. Many of the areas for improvement are ongoing. A few have been completed. For example, the diagnostic identified that the Board had not adequately monitored private fostering arrangements; this was rectified mid-2015. Action plans from serious case reviews completed several years ago, which had not been signed off, have also subsequently been completed.

127. Following the LGA diagnostic, the Board established a challenge log to better evidence the range of issues raised by its partners and the independent chair. This has enabled partners to provide transparent and constructive challenge to each other and for the Board to track outcomes. For example, the DCS recently challenged police colleagues about a period around August 2015 where domestic abuse notifications had not been promptly referred.

128. The Board has begun to review, rationalise and re-organise its sub-committees and this was underway at the time of the inspection. One of the key sub-groups overseeing performance management and quality assurance has been hampered in fulfilling its functions through having an extensive work programme, changes in membership and inconsistent chairing arrangements. Two core areas of its work have not been undertaken with sufficient rigour. A multi-agency dataset has been developed, combining performance information gathered by key partner agencies. This is regularly reported to the Board, with some analysis of issues and trends. However, the dataset is too broad and does not readily align to the Board's priorities. The sub-group also ensures that partner agencies regularly report on how they safeguard children through Section 11 reports and through reports from schools. These have been updated on a bi-annual cycle and will be renewed from November 2015. While the response from key agencies has been high, the sub-group has not had the capacity to effectively monitor or influence agency plans, or to collate returns from schools.

129. While the Board monitors a wide range of safeguarding activity, for example through a multi-agency audit programme, it has not sufficiently monitored the effectiveness of multi-agency child protection core groups. During the inspection, cases were identified where core groups had been irregular and ineffective. The MSCB has identified this deficit and plans to address it through the work plans of its subgroups.

130. Engagement and commitment by all partner agencies to the MSCB are strong, with attendance by representatives at the right level from all partner agencies. Attendance by some partners at some sub-committees in early to mid-2015 was inconsistent and this impacted negatively on their work. The independent chair appropriately challenged partners to secure improved attendance in recent months. Two lay members have been recently appointed to the Board.

131. The influence of the MSCB in the oversight and scrutiny of early help services has, until recently, been limited. While reports on early help services have been received, the Board has not systematically evaluated the effectiveness of the early help offer. As the local authority has developed its early help strategy, the MSCB has, more recently, taken a more active role in overseeing its development. This includes considering the potential impact of the strategy on reducing the high numbers of children requiring child protection plans.

132. The MSCB has developed close links with the local Medway Secure Training Centre and the Young Offender Institute (YOI) (Cookham Wood) and ensured that representatives from these establishments are engaged with the Board and its sub-groups. The Board receives regular safeguarding reports from these representatives and the chair takes a direct and active interest in how vulnerable young people are safeguarded. The Board has recently signed off the long-standing action plan for a serious case review for the YOI. At the time of inspection, the Board had been notified of a further case review involving the YOI for an out-of-area young person. The Board has recently decided to introduce a task and finish group to focus specifically on safeguarding for this group of young people placed in YOIs.

133. Clear and detailed safeguarding policies and procedures are developed, implemented and monitored through the MSCB. A joint Medway and Kent policy and procedures sub-group oversees these, producing joint policies and protocols, benchmarked regionally and nationally to ensure consistency. Some policies are modified to reflect issues specific to Medway. For example, revised thresholds processes have been developed and disseminated which are well understood by partners. The MSCB has appropriately monitored the development of the Contact, Advice and Duty Service, the application of thresholds and the joint work of partners to assess and protect children.

134. The MSCB has ensured that clear protocols are in place for partners who work with the most vulnerable children, that these groups are included within its priorities for 2015–17, and that training and awareness-raising sessions are provided. Appropriate training is in place for professionals working with children who go missing, those at risk of child sexual exploitation, those at risk of radicalisation and those who are exposed to domestic abuse. The Board has monitored the effectiveness of the multi-agency sexual exploitation panel and the development of a multi-agency sexual exploitation team, in collaboration with partners in Kent. Intelligence and information on children at risk of child sexual exploitation is appropriately shared between partners. This was well evidenced in two major child sexual exploitation operations across Kent and Medway in the past year, led by the police with close collaboration of partners. Although partners collate the right information relating to children at risk of child sexual exploitation, a comprehensive child sexual exploitation dataset has not been established to inform service development. This is planned as part of the work in the multi-agency team.

135. The Medway Child Death Overview Panel fulfils its statutory functions, with appropriate steps taken to address local modifiable factors in child deaths, such as smoking in pregnancy. The panel is well constituted and attended and is appropriately challenging. The work of the panel has led to changes in procedures and practice, for example child sexual exploitation, in the development of a policy to respond to parents who do not attend health appointments for children with long-term health conditions. The impact of this policy is in the process of being evaluated.

136. The MSCB team (business unit) has experienced a period of staff changes. During the past year, permanent staff have been appointed and roles redefined to enable it to provide better support to the Board and its groups.

137. The MSCB established a young person's safeguarding panel in May 2015, to engage young people of diverse backgrounds and ages in its work. At the time of the inspection, 11 young people were involved. They contributed to the recent recruitment process for lay members, and to the Board's review of its work in raising awareness of domestic abuse in the community. Young people from this group seen by inspectors were enthusiastic and committed to developing their role and their voice on the Board.

138. The MSCB has ensured that a wide range of multi-agency safeguarding training is developed and delivered to its partners. This is provided in ways that are readily accessible to staff, such as e-learning and short sessions. Training is appropriately graduated according to the experience and needs of learners. Core child protection training is provided, alongside workshops to address key safeguarding issues such as female genital mutilation, Prevent and child sexual exploitation. These are well aligned to local need. Members of the learning and development sub-group effectively oversee the quality of training, supported by learning and development officers. The MSCB has recognised the need to strengthen its evaluation of the impact of training, which is primarily based on post-course self-evaluation. Response rates to questionnaires three months after course dates have been low and as a result the Board is unable to fully evaluate the impact of training on practice.

139. The MSCB has established six overarching priorities, reviewed for 2015–16 to ensure that they incorporate current safeguarding issues. These are now better aligned to the business plan and to the work of the sub-committees. The MSCB annual report for 2014–15, approved by the Board at the time of this inspection, provides a realistic synopsis of the work of the Board, the range of work undertaken to safeguard children and some commentary of what impact the Board and its sub-groups have had. This is significantly better than previous annual reports, although it could provide greater focus on the impact of the Board on safeguarding practice.

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 eight of Her Majesty's Inspectors (HMI) from Ofsted.

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