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6 April 2017

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Dear Dawn

Third monitoring visit to Wandsworth children's services

This letter summarises the findings of the monitoring visit to the London Borough of Wandsworth children's services on 7 and 8 March 2017. The visit was the third monitoring visit since the local authority was judged inadequate for overall effectiveness in December 2015. The inspectors were Brenda McLaughlin HMI and Marcie Taylor HMI.

The local authority is making steady progress in improving services for most children and young people. Leaders and managers have a comprehensive knowledge of their strengths and areas for development. In the cases sampled, a small number of children were referred to senior managers due to delays in progressing work or where the risks to children missing or sexually exploited lacked sufficient management oversight and action.

Areas covered by the visit

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

- the use and effectiveness of the Public Law Outline (PLO) to ensure that children at risk of significant harm do not experience delay if they need to be in care
- the quality of practice and permanence planning for children accommodated under section 20 of the Children Act 1989
- the quality of practice to protect children missing from home and care or at risk of sexual exploitation.

The visit considered a range of evidence, including electronic case records, supervision files and notes. We reviewed improvement plans and performance information and commented on the quality and impact of audit activity and the

effectiveness of management oversight. In addition, we spoke to a range of staff, including managers and social workers.

Overview

The local authority is continuing to make solid progress. Most children are safer as a result of effective identification of risks and timely action by managers, preventing further harm. However, the local authority is fully aware, from extensive and effective audit activity and reviews, that social work practice is not yet consistently good enough across all services. There are still some aspects of ineffective work, for example insufficient information sharing and management oversight of some children looked after who go missing or are at high risk of sexual exploitation.

Findings and evaluation of progress

Based on the evidence gathered during the visit, social work practice is becoming stronger, leading to better outcomes for most children. Social workers spoken to by inspectors know children well. They see them regularly and carry out imaginative child-centred direct work that is informing decisions and plans. The consistent use of the Signs of Safety and Well-being (SoSWB) templates in most teams ensures effective focus on risk.

Management direction and oversight of practice, including those by senior managers, are becoming more established. Supervision records seen in the children in need and looked after teams are comprehensive, with evidence of management reflection and clear actions and expectations that are reviewed at the next session. The local authority's recent review of the youth support teams (YST) has identified that the quality of supervision and management direction in these teams is more variable.

Managers are taking effective action to improve the quality of practice for 64 children looked after under section 20 in the YST service. All new section 20 cases will be expected to have plans for permanence made at the second statutory review. Regular meetings between managers of the independent reviewing officers (IROs) and the YST are improving the timeliness of work with children, preventing drift. The local authority accepts that work with these young people is variable. Their plans to reconfigure these teams as part of the local authority's 'end-to-end review' are intended to improve the quality of practice overall.

The management systems within the PLO to support robust oversight of children at risk of significant harm are at an early stage. These include the development of a clear pathway, supported by practice guidance, to provide consistent understanding and application of thresholds for pre-proceedings. Legacy issues of previously poor practice have resulted in delays for some children. However, legal planning meetings, now chaired consistently by one manager, and a multi-agency quality assurance panel that reviews all children subject to a child protection plan for longer than 12 months, and children under five after nine months, are resulting in appropriate action to reduce risk. Letters before proceedings are of good quality. They use

accessible language, they are individualised and they detail clearly for parents and children why there are concerns and what needs to change. Review PLO meetings appropriately assess the impact and progress made on each case, reducing delay.

Some cases sampled of children missing from care and those at high risk of sexual exploitation lacked an up-to-date accessible assessment of risk or evidence of timely management oversight. Not all missing from home and care assessment plans or the child sexual exploitation risk assessment documents are comprehensively completed or clear enough. This means that certain performance information is unreliable. For example, too often the most recent missing episode referred by the police was not included. In some cases seen, information from the sexual exploitation multi-agency panel (SEMAP), which considers all children at actual or potential risk of sexual exploitation, was missing or not uploaded onto the system. Senior managers accepted inspectors' concerns. They are aware from their audit activity that, while they have made considerable improvement, more work is required to ensure that outcomes for these children improve.

This visit found continued improvements in effective direct work with most children, helping to protect them from harm. A relentless focus on the quality of practice and performance means that senior leaders know what is happening in frontline practice. While the pace of change is steady, the local authority accepts that, in some areas, social work practice is not reliably good enough and it is taking decisive action to address these deficits.

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

Yours sincerely

Brenda McLaughlin

Her Majesty's Inspector