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3 April 2018

Ms Linzi Roberts-Egan
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Dear Ms Roberts-Egan

Focused visit to the London Borough of Waltham Forest children's services

This letter summarises the findings of a focused visit to the London Borough of Waltham Forest children's services on 7 and 8 March 2018. The inspectors were Tara Geere, HMI, and Alison Smale, HMI.

Inspectors considered the local authority's arrangements for child in need and child protection services in accordance with the Inspection of Local Authority Children's Services framework. Specifically, they looked at the arrangements for receiving and responding to contacts, referrals and requests for early help within the multi-agency safeguarding hub (MASH).

Inspectors considered a range of evidence, including case discussions with social workers, child protection chairs, managers, and a number of partner agencies. They also looked at local authority performance management and quality assurance information, as well as children's case records.

Overview

Since the last inspection of services in 2014, there has been significant work to further develop the MASH. This includes the co-location of more partner agencies and a recent relaunch of the revised threshold guidance. This in turn has resulted in improved, timely multi-agency responses to contacts and referrals. Regular surveys

of partner agencies show improved understanding and better relationships with children's social care, and this is enabling better support and protection of children.

Child protection concerns are quickly identified, leading to timely interventions to safeguard children and reduce risk. In the cases considered, inspectors did not find any children at risk of harm who the local authority had not already identified and provided with an appropriate service to meet their needs.

Senior leaders know their services well and are focused on improving social work practice for children and their families. Strong corporate and political support is ensuring that targeted resources are available to improve services. Additional frontline social worker and managerial posts have led to a reduction in caseloads, enabling social workers to provide more effective support to children and their families. Social workers who spoke with inspectors reported that they feel well supported and valued.

Recent changes to the electronic recording system have resulted in inaccuracies in some performance management reports. This means that managers do not have a comprehensive, accurate understanding of the effectiveness of practice. Senior managers are aware of this and have taken robust action to improve data quality through a data cleansing exercise.

What needs to improve in this area of social work practice

- Management oversight and rationale are consistently evident in case records. However, the actions required to be taken are not always specific and measurable, meaning that the progress of children's plans is harder to monitor.

- The implementation of the newly commissioned local authority case recording system has resulted in some performance management reports not being sufficiently accurate. This restricts the ability of leaders and managers to have a systematic understanding of interventions and to monitor the quality and timeliness of social work practice.

- The quality assurance framework audits focus on process compliance. In order to drive continued improvements, further development is required to evaluate the quality of practice and to consider how this impacts on outcomes for children.

Findings

- Work with partners, including the development of the recently revised and relaunched threshold document, has resulted in partner agencies having a better understanding of thresholds. Contacts received by the MASH show appropriately detailed requests for help, support and protection.

- The vast majority of information-sharing by partners is prompt and of good quality, and is supported by the co-location of partners in the MASH. The daily risk management meeting, attended by a wide range of partner agencies, allows timely and effective information-sharing that is used to assist in risk analysis and decision-making. There is robust consideration of historic involvement, patterns and risks in order to safeguard children from further harm. Consent is appropriately sought, or overridden when necessary.

- Decision-making on contacts, including out-of-hours contacts, is appropriate and results in timely progression to referrals for early help and statutory services. This ensures that children and families receive the appropriate services at the right time. The rationale for decision-making is clearly recorded. Referrers receive timely responses to inform them of the actions taken to safeguard children, following their requests for help, support and protection.

- Child protection concerns are quickly identified and progress to timely strategy discussions; the planned interventions safeguard children effectively. However, strategy discussions do not routinely include all of the relevant agencies. This is a missed opportunity to improve information-sharing, decision-making and planning for children.

- The vast majority of case recording is up to date, with ethnicity clearly recorded. However, consideration of the impact of children's diverse needs is not consistently taken into account in assessments and planning.

- The majority of assessments are completed in a timely way, with clear direction and focus provided by the team manager. Assessments reflect the lived experiences of children, ascertaining their wishes and views. Social workers are persistent in following up and finding different ways to contact and engage with very challenging families.

- When children's cases are stepped down to early help following assessment, there are clear packages of support in place from appropriate services to support sustained progress for children.

- Referrals to the designated officer regarding allegations against staff receive a timely response, despite there being an increase in volume. Inspectors saw appropriate action taken on cases sampled. Recording is not up to date in a small minority of cases. Senior managers have identified additional resources to increase capacity to ensure that records are thorough and of good quality.

- Robust arrangements are in place to identify and respond to missing children. The adolescent risk matrix is an effective tool to risk assess and inform future planning for vulnerable young people. However, return home interviews are not yet undertaken with all children. This limits the quality of information shared with agencies to underpin individual and strategic responses to protect vulnerable children and to reduce the risk of further harm.

- Social work teams are benefiting from an increasing number of permanent staff. Teams have been strengthened by additional frontline social worker and managerial posts and the cohorts of newly qualified social workers. This has resulted in manageable caseloads and better oversight of cases.

- Social workers who spoke to inspectors report regular, reflective supervision and easy access to managers, including senior managers, who support them in their roles. Social workers have sufficient time to undertake direct work and develop meaningful relationships with children and families.

- Staff have access to a wide range of induction and training opportunities. They report that the access to and quality of training are significant factors in their deciding to remain working for the local authority; they value the regular workshops and the monthly practice forum. These events provide them with opportunities to reflect and focus on practice improvement, and give them space to think creatively when facing new challenges.

Ofsted will take the findings of this focused visit into account when planning your next inspection or visit.

Yours sincerely

Tara Geere

Her Majesty's Inspector