Isle of Wight Council

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: 16 September 2014 – 8 October 2014

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The overall judgement is that children's services require improvement
The authority is not yet delivering good protection and help and care for children, young people and families. It is Ofsted's expectation that, as a minimum, all children and young people receive good help, care and protection.

The judgements on areas of the service that contribute to overall effectiveness are:		
1. Children who need help and protection		Require improvement
2. Children looked after and achieving permanence		Require improvement
	2.1 Adoption performance	Require improvement
	2.2 Experiences and progress of care leavers	Require improvement
3. Leadership, management and governance		Require improvement

[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 Inspection 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.

Contents

The local authority

Summary of findings

Children's services in Isle of Wight Council require improvement because:

Quality of practice

- The quality of practice is not yet consistently good enough. This includes variation in the quality of direct work with children, assessment, recording, timeliness of meetings and the effectiveness and progress of planning for children.
- Children looked after do not all benefit from timely initial health assessments and reviews of their health needs, and one in five are not registered with a dentist.
- The educational outcomes for some children looked after on the island are poor.
- Some children who are looked after or have been adopted, their carers and care leavers do not have the full information that they require.

Management, quality assurance, partnership governance

- Issues of management capacity at both service manager and team manager levels limit the effectiveness of oversight of intervention with some children.
- The supervision and oversight of social workers is not sufficiently regular or of a consistently good quality.
- Independent reviewing officers (IROs) are not delivering their full role: they are not routinely visiting all children between their formal review meetings.
- The recruitment of adopters is not yet supported by a detailed marketing strategy.
- Elected members do not currently provide effective scrutiny of children's services nor fully embrace their role of corporate parent for children in care.
- The leaving care service does not yet provide services that ensure that all care leavers have the support to achieve positive outcomes in their adult lives.

Systems and processes

- Multi-agency arrangements for children and young people who go missing or who are at risk of sexual exploitation need to be strengthened: 'return interviews' are not routinely completed.
- Despite improvements to the integrated children's system (ICS), social workers and managers still do not always have easy access to full case records in relation to children and their families.

What does the local authority need to improve?

Priority and immediate action

Capacity

1. Ensure that service managers have sufficient capacity to undertake their full role, including supporting and monitoring the work of team managers.

2. Ensure that the Children in Care Team has sufficient capacity, at both team manager and social work levels, to ensure that a consistent and good quality service is provided to children in care.

3. Ensure that all missing episodes are systematically referred to National Youth Advocacy Service (NYAS) for return interviews to be completed within 72 hours.

4. Ensure that all children looked after are registered with a dentist.

Areas for improvement

Quality of practice

5. Further improve the quality and consistency of social work assessment, analysis, direct work with children and young people, and recording.

6. Ensure that meetings, such as child protection conferences, core groups, child in need meetings and children looked after health assessments, are convened within required timescales.

7. Ensure that child protection plans, child in need plans and care plans are specific, timely and that progress is routinely reviewed to ensure that risk and need are being reduced effectively for children.

8. Continue to improve school attendance and educational outcomes for children looked after.

9. Ensure that all foster carers have sufficient detailed information about their delegated authority.

10. Ensure that life story work includes all important parts of a child's life in order to create a complete and lasting record.

11. Ensure that care leavers are aware of their entitlements.

Management, quality assurance, partnership and governance

12. Enhance the skills and capacity of front-line managers. Continue to risk assess and address poor performance.

13. Ensure that elected members effectively challenge performance and support improvements within children's services.

14. Review and improve the effectiveness of the corporate parenting panel, its links with young people and the role of elected members as champions for children looked after and care leavers.

15. Ensure that IROs have sufficient capacity to fulfil their statutory role.

16. Ensure that all team managers manage and monitor the work within teams effectively, including the provision of regular and good quality supervision for social workers and that audits are consistently rigorous.

17. Ensure that the placement sufficiency strategy is informed by a thorough need and trend analysis that also considers the sufficiency of adoptive placements.

18. Develop an adoption marketing strategy to increase the pool of Isle of Wight adopters and ensure that statutory timescales are achieved for the assessment of potential adopters.

19. Develop more formal links between the chair of the adoption panel and senior managers in order to improve adoption performance.

20. Continue to embed the new service for care leavers and enhance provision through developing the Staying Put programme, fully implementing the peer mentoring programme and increasing the numbers of care leavers engaged in education, employment and training.

Improved outcomes for children through effective systems and processes

21. Continue to resolve issues with the ICS to ensure that all relevant documents are stored in children's case files and readily accessible for workers and managers. This should also include implementing the IT solution to enable adoption documents to be brought together into one effective secure record.

The local authority's strengths

22. The five-year strategic partnership between the Isle of Wight Council and Hampshire County Council is providing essential stability and is driving demonstrable improvements across children's services on the island.

23. Strong senior management oversight and direction is being provided by Hampshire County Council. Senior managers and leaders now have a sound understanding of children's services on the island and have a robust improvement plan in place that is providing an effective framework to shape developments.

24. The strategic partnership has also enabled the swift update and implementation of a large range of sound operational policies and procedures for staff.

25. Hants Direct, the contact and referral service for the Isle of Wight and Hampshire, is operating clear thresholds and is providing effective and timely response to referrals for children and their families. The multi-agency safeguarding hub (MASH) further strengthens the 'front door' through effective information sharing.

26. The intensive support service (ISS) provides effective support to children, both as an early help intervention to prevent the need for children to become looked after and also as a support to placements that are vulnerable to breakdown.

27. The disabled children's team is working effectively and sensitively with disabled children and their siblings to ensure that they are protected and that their range of needs are being met.

28. There is a strong and effective commitment to placing brothers and sisters together when it is in their best interests to do so.

29. The role of a Social Care Educational Professional (SCEP) has been developed to support the educational attainment of children looked after.

30. The fostering team are on target to recruit an ambitious number of new foster carers. Existing foster carers report that they receive good support from the team.

Progress since the last inspection

31. The last Ofsted inspection of Isle of Wight Council's arrangements for the protection of children was undertaken in November 2012. The local authority was judged to be inadequate. The last Ofsted inspection of Isle of Wight Council's services for looked after children was in September 2010. The local authority was judged to be adequate.

32. The council had a robust and effective response to the areas for improvement in the 2012 inspection and, with the support of the children's improvement board, has addressed the vast majority of required actions. However, there are some actions that require ongoing focus from the local authority to further embed and secure improved outcomes. These include continuing to improve the quality of performance information as the new ICS develops and establishing routine processes to ensure that service planning is informed by the views of service users.

33. Given the length of time since the 2010 inspection and the impressive progress seen since the 2012 inspection, particularly following Hampshire senior managers joining in July 2013, the focus for this section will be taken from the 2012 inspection only. Improvements over these past 18months include:

    - agreeing the strategic partnership between Hampshire and the Isle of Wight, which is having a positive impact on improving services to children and their families

- implementing a range of sound policies, procedures and practices, adopted from Hampshire, which is described by workers as providing a useful 'roadmap' for their work
- a range of complementary actions and improvements have been secured within the Isle of Wight's children's social care over the past 18 months. These include:
  - securing the 'front door' through joining Hants Direct – children and young people who are at risk are now identified and have a timely response
  - restructuring children's services, which has ensured that there is clear line management accountability for all teams, and establishing new Child in Need and Leaving Care Teams
  - improving senior managers' engagement with partner agencies, leading to better communication and more collaborative working
  - ensuring that thresholds for intervention now accord with legal requirements – this means that children in need of help and protection are identified by professionals and that statutory work is clearly and effectively differentiated
  - embedding legal planning and public law outline (PLO) meetings to improve the quality and timeliness of decisions made when instigating care proceedings
  - implementing a permanency planning process, which is improving outcomes for children and young people
  - ensuring that all children and young people looked after have care plans
  - increasing foster carers' allowances
  - recruiting social work staff , including a number who are newly qualified, and thereby reducing the number of agency workers
  - implementing training for Lead Professionals – this is increasing confidence in the role and ensuring that children in need of help and those requiring protection are clearly differentiated.

Summary for children and young people

- When the Isle of Wight Council was last inspected at the end of 2102, their services for protecting children were inadequate. This meant that they did not have the right services in place to protect children properly. There were also a lot of children who should have had a social worker but did not.
- The council needed to do something bold to make things better for children and their families on the island. So they asked managers from Hampshire to help, and they started to work on the island in July 2013. Since then, services for children have got better, but they still require improvement to be good.
- One of the most important things the council has done is to make sure that when people have a concern about a child that they refer to the council, it is now responded to quickly and children receive the right help at the right time.
- The services in place to protect children from harm have also improved. Children are now less likely to be at risk of significant harm once they have a social worker. Like other parts of the service, this needs to continue to improve to make sure that all children are receiving good help, support and protection.
- The children in care service is under a lot of pressure at the moment and we have asked the council to look at this and improve it straight away. We found that too many children had experienced too many changes of social worker.
- The island's politicians could do more to make sure that children in care do better, both during their childhoods and also later into their adult lives.
- A new service for young people leaving care has been set up. This means that all care leavers now have a person they can talk with and get advice from. Care leavers told us that this has made a really big difference to them. This is a new service that still has lots of work to do, including helping more care leavers to be involved in education, training or employment.
- A new structure of teams has been established and more staff have been recruited to work on the island. Again, there is more work to do to make sure that all staff and managers have the time and skills to be able to do their work well, but the council has strong plans in place to do this.

Information about this local authority area[2]

Children living in this area

- Approximately 26,168 children and young people under the age of 18 years live on Isle of Wight. This is 19% of the total population in the area.
- Approximately 20% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 18% (the national average is 18%)
  - in secondary schools is 13% (the national average is 15%).
- Children and young people from minority ethnic groups account for 5% 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 Mixed and Asian or Asian British.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 3% (the national average is 18%)
  - in secondary schools is 2% (the national average is 14%).
- There are a small number of Travellers and a larger Eastern European population that seeks seasonal work in the agricultural parts of the county but who are not resident.

Child protection in this area

- At 31 August 2014, 1,299 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 1,232 at 31 March 2013.
- At 31 August 2014, 219 children and young people were the subject of a child protection plan. This is an increase from 101 at 31 March 2013.
- At 31 August 2014, one child lived in a privately arranged fostering placement.

Children looked after in this area

- At 31 August 2014, 183 children are being looked after by the local authority (a rate of 70 per 10,000 children). This is an increase from 179 (69 per 10,000 children) at 31 March 2013. Of this number:
  - 20 (11%) live outside the local authority area

[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.

- 20 live in residential children's homes, of whom five live out of the authority area
- five live in residential special schools[3] all of whom live out of the authority area
- 128 live with foster families, of whom seven live out of the authority area
- 16 live with parents, of whom none live out of the authority area
- There are no children who are unaccompanied asylum-seeking children.

- In the last 12 months:
  - there have been four adoptions
  - 20 children became subject of special guardianship orders
  - 87 children ceased to be looked after, of whom 13% subsequently returned to be looked after
  - 12 children and young people ceased to be looked after and moved on to independent living
  - eight children and young people ceased to be looked after and are now living in houses of multiple occupancy.

Other Ofsted inspections

- The local authority operates one children's home, which was judged to be good in their most recent Ofsted inspection.
- The previous inspection of Isle of Wight's safeguarding arrangements/arrangements for the protection of children was in January 2013. The local authority was judged to be inadequate.
- The previous inspection of Isle of Wight's services for looked after children was in October 2010. The local authority was judged to be adequate.
- The previous inspection of the Isle of Wight's fostering service was in September 2010. The local authority was judged to be satisfactory.
- The previous inspection of the Isle of Wight's adoption service was in September 2011. The local authority was judged to be satisfactory.

Other information about this area

- The Director of Children's Services has been in post since July 2013.
- The Chair of the LSCB has been in post since October 2013.

[3] These are residential special schools that look after children for fewer than 295 days.

Inspection judgements about the local authority

Key judgement	Judgement grade
The experiences and progress of children who need help and protection	Requires improvement

Summary

Since the last inspection there have been demonstrable improvements in the help and protection provided to children and their families by Isle of Wight Children's Services. Children and young people at risk of harm or abuse are now being accurately identified by Hants Direct and appropriately provided with statutory services to reduce the risk of harm. Children in receipt of early help continue to benefit from a range of good early help services.

Thresholds for intervention now accord with legal requirements and statutory work is clearly and effectively differentiated. As a result, most children receive the right level of help. The quality of practice, although improving, is still too variable. Caseloads have been reducing to more acceptable levels. However, they remain too high for some social workers, which limits their effectiveness.

Most child protection conferences are well attended and information about risks to children are analysed. There is some delay in convening initial child protection conferences, but no children were found to be at risk as a result. Some core groups are not being held on time and recording of the progress against the child protection plan is not yet consistent.

There is a need to strengthen multi-agency arrangements to protect, monitor and review children and young people who go missing or who are at risk of sexual exploitation through ensuring that 'return interviews' are routinely completed.

34. Children and young people on the Isle of Wight benefit from access to a wide range of improving Early Help Services. The remodelling of these services with a focus on children's centres, aligned to three locality hubs, has strengthened collaboration across agencies. This ensures that most children and their families receive the right level of support. Strong and effective partnerships are improving outcomes for children. Consequently, young people at risk of harm or on the edge of care are being identified earlier and helped to prevent issues escalating. The intensive work of the Targeted Youth Support service and the Strengthening Families team (Troubled Families) is successfully helping children and their families to make positive changes. For example, inspectors found children over the age of 10 being assisted to engage with mental health services, increase their attendance at school and improve relationship with their parents.

35. Common Assessment Framework (CAF) processes are clear and management oversight is robust. Although most CAFs seen by inspectors (six out of 10) require some improvement, the new format, introduced in April 2014, places the voice of the young person firmly at the centre of the process. Training for Lead Professionals is increasing confidence in this role and ensuring that children in need of help and those requiring protection are clearly differentiated. This is a noteworthy improvement since the Ofsted inspection in 2012. Staff reported that this is underpinned by clear threshold pathways via Hants Direct and the Children's Referral Team (CRT). An outcomes tool (distance travelled) completed with young people and their families is effective in measuring individual progress and is also aggregated to evidence the impact of the Early Help services. Parents reported to inspectors that they are happy with the service they receive.

36. Evidence from this inspection demonstrates that the strategic partnership with Hampshire County Council has improved the system 'at the front door'. Children and young people at risk of harm, neglect or abuse are now accurately identified and protected. All new referrals to Isle of Wight Children's Social Care are handled on the mainland by Hants Direct. Effective management oversight ensures that threshold decisions are correctly applied. The CRT makes appropriate and timely decisions in the progression of cases to the multi-agency safeguarding hub (MASH) or in signposting referrers to the Early Help team on the island if a CAF or more targeted support is required. As a result, in the vast majority of cases seen within this service, children and their families were getting help at the right time and at the right level.

37. Children and young people on the island requiring immediate safeguarding action via S47 child protection enquiries and assessment are referred directly from the MASH to the Referral and Assessment Team electronically, followed up with a telephone call on the same day. This provides a comprehensive understanding of the concerns and ensures that children's cases are allocated promptly. Children are seen and seen alone and social workers focus appropriately on securing their views. Of cases sampled, most were assessed in accordance with timescales set by the local authority and proportionate to the presenting level of concern. Until recently (July 2014), the volume of work in the referral and assessment team was too high and this affected the quality of some assessments. Team manager absence over the summer of 2014 affected the regularity of supervision and performance monitoring. Additional management capacity is beginning to address these concerns, but more work is needed to achieve a consistent quality.

38. The Out of Hours Service is managed by Hampshire County Council, with staff available on the island to carry out urgent child protection work. In cases seen by inspectors, the quality of the work was good. There is an effective joint protocol between housing and the local authority that ensures that young people at risk of homelessness or who are homeless receive a prompt accessible service. There have been three homeless young people since October 2013. Family solutions were found for two and the other young person was accommodated.

39. Children and their families requiring longer term support and protection are transferred from the Referral and Assessment Team to the Children in Need (CIN) Teams. There has been a substantial increase in the work of these teams, partly resulting from the new management arrangements but also due to a considerable increase in the number of contacts coming into Children Services. This is understood to be the result of an increase in confidence across the partnership that Children's Services have become more effective and responsive.

40. The single assessment framework is now being used across the social work teams, including being used to support child protection section 47 enquiries. The quality of assessments is variable, with most being satisfactory or better. Weaknesses included a lack of consideration of the experiences of the child and some examples of poor information sharing with partner agencies. There is also a lack of effective use of chronologies within almost all cases seen, although consideration of the history in the case is evident within assessments. During the inspection, there were no cases formally referred back to the local authority where inspectors believed children were at immediate risk of harm: in one case raised by inspectors, the young person required immediate safeguarding action, which was taken promptly.

41. Strategy meetings and section 47 enquires carried out on the Isle of Wight by the CIN teams, while timely, are variable in quality. Weaknesses are reflective of those found in the use of the single assessment, including some examples seen where there was limited information sharing with other agencies and only a brief enquiry report that lacked sufficient exploration of current issues and failed to take account of the views of children and parents. There has been insufficient management challenge in some of these cases, which has affected the quality of the child and family assessment. In contrast, a further sample seen was of a good standard, involving a range of professionals and providing evidence of robust management direction and review.

42. Social workers have access to good quality and appropriately focused training and receive regular briefings from the LSCB in relation to learning from serious case reviews. They were able to speak of learning in relation to disguised compliance, domestic abuse and the importance of including historical factors in their analysis. Information on the prevalence of domestic abuse, substance misuse and parental mental health is not routinely collated in open cases and, as a result, the local authority cannot be sure it is providing appropriate support to its local communities. A positive, collaborative partnership between the Independent Drug and Alcohol Service, Woman's Refuge and Adult Mental Health services is making a positive difference to children and their parents. The multi-agency risk assessment conference (MARAC) and multi-agency public protection arrangements (MAPPA) chairs report significant improvement in the consistent involvement of children's social care at their meetings. Consequently, information sharing and joint work with the police and probation is more effective in high risk domestic abuse cases.

43. The council's performance on convening Initial Child Protection Conferences within 15 days of a strategy discussion is poor and related to the increased volume of work in the teams. For example, 27% were out of timescale in June, rising to 42% in July and 41% in August. The vast majority of child protection review conferences are held within timescales (95%) and are well attended, with chairs encouraging participation from all attendees and key information about risks and protective factors being analysed in order to reach an appropriate decision for each child. The quality of child protection plans seen is variable, with some outline plans not being sufficiently outcome focused while others were good.

44. Some core groups are infrequent or cancelled at short notice and recording of the progress against the child protection plan is inconsistent. Inspectors observed notes from a previous core group being distributed at the current meeting, making it challenging for families and core group members to have a record of what was agreed in order to progress their actions. Manual management systems to track, record and analyse performance information at team level about the frequency of core groups, child protection visits and CIN meetings are not fully reliable.

45. Children and families receive services that are responsive to issues of gender, sexuality and disability. However, needs relating to ethnicity are not routinely recorded or considered in social work assessments.

46. Disabled children receive a good service from a skilled and stable team. In most of the cases seen, the quality of safeguarding assessments for disabled children and their brothers and sisters was good. They have access to a good range of support services, including short breaks, after-school clubs and holiday schemes. There is effective management oversight and regular supervision of workers. Inspectors met with Young Inspectors who have disabilities. They carry out inspections of short break provision and provided positive examples of where their work has improved services. For example, they visited a short break holiday park and, as a result, access for wheelchair users has improved. They also secured additional resources to enable a football team for disabled children to be based within a local leisure centre.

47. Multi-agency arrangements to protect, monitor and review children and young people who go missing or who are at risk of sexual exploitation are improving. Children who go missing from home, care or education are referred to the MASH and are jointly triaged, working in accordance with the missing children policy. Service managers receive all children and young people missing alerts from the police and ensure that there are 'High Risk Strategy Meetings' in place for children who have repeated missing episodes. More work is required to ensure that 'return home interviews' are routinely referred to NYAS for all relevant young people, as only six out of a potential 21 interviews have been undertaken since April 2014. This information from young people is vital in helping professionals understand the reasons for their behaviour and to inform appropriate multi-agency responses.

48. Although only implemented six months ago, processes via Missing, Exploited and Trafficked Risk Assessment Conference (METRAC) for the multi-agency management of child sexual exploitation (CSE) and missing children are strong. The systematic mapping, tracking and review of young people and perpetrators ensures that information is shared across all agencies and risks are monitored monthly by the METRAC. Dedicated police and social care professionals support this model. At the time of the inspection, there were 29 young people being monitored by the METRAC. All of the 115 children missing from education in 2013–14, apart from one case that remains open, have either been traced or have been included within the national database to monitor children missing education.

49. Arrangements for the management of allegations against professionals are satisfactory. The Local Authority Designated Officer (LADO) was appointed in September 2013 and has made substantial progress in developing effective systems and raising awareness in schools and other settings. This has resulted in an increase in appropriate referrals.

50. More work is required to raise the profile of private fostering and to ensure that children are given the level of protection and support they need. The private fostering annual report 2013–14 highlighted serious concerns, with the action plan in the early stages of implementation. In the two cases seen, the quality of practice was variable: in one case, the child benefited from a good assessment of needs. However, in the other case, the assessment was inadequate with insufficient exploration of the risks and the child's needs.

51. Social workers spoken to know the children they are working with well and are able to articulate their needs, wishes and feelings, although this is not always clear from the case recording. Inspectors met with a group of children and young people (aged from seven to 14 years) who are subject to child protection plans. All of them provided examples of how their social worker helped them. One young person had not been attending school due to bullying and is now attending full time. Most young people talked about frequent changes in worker in the past. All the young people had benefited from the services of an advocate.

52. Although reducing, social work caseloads remain high for some workers. This reflects not only volume but also the complexity of cases. Some staff reported that they are worried about the lack of time they have to see children and carry out direct work. Previous large workloads have affected the quality of some assessments. The creation of an additional CIN team in September 2014 will alleviate some of this pressure. Staff morale is good and workers told inspectors that they now feel supported by managers who are accessible. This includes newly qualified social workers, who say their workloads are protected in relation to child protection work. Inspectors found that supervision for some workers does not happen in line with the local authority's own policy, with some gaps in management oversight of practice, particularly during sickness absence of managers.

53. New policies, procedures and processes are welcomed by staff. They are providing a useful framework as part of the improvement journey to assist staff and their managers to improve the quality of their work with children and young people. Social workers referred to them as a useful 'road map' to guide their work.

Key judgement	Judgement grade
The experiences and progress of children looked after and achieving permanence	Requires improvement

Summary

The local authority has made improvements in the service they provide for children and young people that are looked after in the Isle of Wight. The implementation of legal planning meetings and the Public Law Outline (PLO) process is improving the timeliness and quality of decisions made when children need to become looked after. Children mostly live in stable placements and with their brothers and sisters where it is appropriate for them to do so.

The outcomes for children looked after at Key Stage 4 are not good and improvements are being explored as part of improving educational outcomes for all pupils living on the island. Not all children and young people looked after receive prompt assessment of their health needs, and one in five is not registered with a dentist.

In recent months, there has been some pressure at team manager level and this led to social workers not being fully supported by regular, planned reflective supervision.

Staff sickness and previous changes in social work staff have meant that not all children and young people know their social workers well. All children now have care plans and these are regularly reviewed. However, high caseloads in the reviewing team means that very few children have benefited from seeing their IRO between reviews. The local authority has very recently secured additional capacity for the social work team and is recruiting to increase IRO capacity.

Good work is being done by children and young people on the Children in Care Council (CiCC) to help the local authority to understand their needs, but they need greater support from the local authority to ensure that they are able to represent the voice of a wider range of children.

Elected members are insufficiently aware of the needs of children and young people who are looked after and do not currently act as effective champions for them.

Strong arrangements are in place to recruit and train foster carers. These foster carers value the support they receive from their social workers. Improved permanency planning and PLO processes mean that parallel planning begins early for children who cannot remain with their birth families. Family finding, although persistent, lacks creativity for hard to place children.

The quality of social work with children waiting to be adopted or placed for adoption is improving, but would be further strengthened through greater access to specialist therapeutic services and by more comprehensive life story work.

The new Leaving Care Team is having a positive impact for care leavers. Young people leaving care report improved levels of support from their personal advisers and better planning for their futures. Further improvements are required to ensure that care leavers are actively engaged in education, employment and training and are aware of their entitlements.

54. In August 2014, there were 183 children looked after. Apart from an increase in 2011–12, the number of children looked after has remained relatively stable over the past few years. Appropriate thresholds are applied and no cases were seen by inspectors of children or young people entering care inappropriately.

55. The Intensive Support Service (ISS) was developed as part of the departmental restructure in December 2013 and provides individually tailored support for children and young people who are on the edge of care or who are in care and at risk of placement breakdown. Planning for these children routinely considers whether there is a role for ISS. In July 2014, the ISS was working with 12 children or young people on the edge of care. The service is responsive and has no waiting list. Inspectors saw good examples of detailed practical plans that are written in a way that children and families are able to understand. Progress made is measured using an outcome tool. Parents are positive about the help they receive, commenting in feedback forms, 'My views were included in the plan', 'They asked me what help I needed and the work has helped', 'You were a tremendous support prior to our daughter's return home… we have had a great outcome and we are working well together as a family.'

56. The local authority has taken steps to re-establish processes to ensure that timely and appropriate decisions are made when instigating legal proceedings. Legal planning meetings, chaired by a service manager, are held weekly. Records of these meetings are comprehensive and decisions made about thresholds for proceedings take account of family history and the parents' assessed ability to change. The presence and impact of senior managers in this process is clear and key decisions about the threshold for care and next steps are recorded.

57. The PLO was only fully implemented in the Isle of Wight in February 2014. Delays in the issuing of PLO letters and the convening of pre-proceedings meetings six months ago were seen by inspectors in some cases. Timescales in the past four months have improved overall. Children and young people are now experiencing less delay as a result of a reduction in the average length of court proceedings. Between April and October 2014, the average time for cases to be concluded was 32 weeks. During April to October 2014, 57% of cases were completed within 26 weeks.

58. Inspectors saw examples of plans for children and young people to return home based on thorough assessment. On their return home, children and their families benefit from support offered by the ISS team on practical matters such as benefits, as well as advice on parenting issues. Very few children or young people (one out of 93) who ceased to be looked after during the past 12 months subsequently returned to be looked after. None of the 15 children or young people who returned home in the last six months have returned to care.

59. A large number of Isle of Wight children waited too long to have a plan for permanence agreed. Inspectors saw two cases where the plans for permanence for teenagers were still not clear. The current permanency planning process, which was first implemented in December 2013, is effective and progress is now being made. In the past nine months, 55 permanency planning meetings have been held that were chaired by senior managers. Reports written by social workers for these meetings are comprehensive and analytical. Plans are clear and are reflected in statutory reviews. The local authority knows that there is further work to do to ensure that all areas of the service are thinking about permanence from the point of first referral to children's social care.

60. Children mostly live in stable placements. In 2012–13, 13% of children looked after had experienced three or more placements during the year – slightly higher than 11% in similar authorities. In March 2014, 15% (29) of children and young people looked after were placed out of the authority. Twelve of these were in residential special schools or other specialist units. A strength of this local authority is placing children in homes with their brothers and sisters when it is in their best interest to do so and even where they are part of a large family.

61. Inspectors have seen the negative impact of the changes in staff and staff absence through sickness on the frequency of visits and the quality of relationships some children and young people have with their social worker. With a more stable workforce now in place, children are benefiting from improved relationships with social workers, including for those young people placed outside the local authority area. One young person said: 'she listens to my views and what I have to say. She can tell if I am in a bad mood, she gives me time to calm down before acting… She's a really good social worker.' The service manager monitors compliance with visiting requirements. However, this data is gathered manually. In one case considered by inspectors, a large gap in visiting was not identified as a result of an error with the manual system.

62. The acting manager in the Children in Care team is visible and available to staff, but capacity at team manager level has led to gaps in formal reflective supervision. Staff sickness has affected workers' ability to complete their work in a timely manner. Although the local authority took steps to increase managerial and worker capacity in this team shortly prior to this inspection, it remains fragile.

63. The local authority has taken action to ensure that children and young people have a care plan to make their needs known and understood and to ensure that children's progress is secured while they are looked after. In all cases seen by inspectors, care plans were in place. Not all were detailed and fully up to date, but examples were seen of plans that clearly identified needs, including those arising from young people's religion and ethnicity. Children and young people are supported to enjoy a wide range of leisure activities that meet their individual needs. Inspectors saw examples of children and young people involved in cubs, fishing, the Duke of Edinburgh award scheme and army cadets as well as sports such as swimming, football and basketball. The local authority also provides children and young people with subsidised membership of leisure centres.

64. Care plans are reviewed, but the timeliness of reviews has fluctuated over recent months and fell to 85% in August 2014. The quality of reviews seen by inspectors ranged from poor to good. Inspectors have seen IROs giving detailed attention to the progress of actions agreed at previous reviews. However, in some cases seen, progress has been hampered by changes of social worker. In one review observed by inspectors, sensitive chairing supported the full participation of the young person in the meeting. In another, young parents were effectively supported to participate fully in their baby's review.

65. Although IROs' caseloads for children looked after do not exceed the 50–70 cases recommended by the IRO handbook, when combined with the child protection case conferences that they also chair, caseloads range from 61 for a part-time IRO to 99 for a full-time IRO. Capacity issues mean that IROs are not fulfilling all their statutory responsibilities. Very few examples were seen of IROs visiting or tracking children and young people between their reviews. The IRO service has until very recently been ineffective in challenging poor practice. Revision and re-launching of the alert and dispute resolution process during the summer 2014 is beginning to show signs of impact.

66. IROs are responsible for producing notes of children looked after reviews and capacity within the team has delayed the distribution of review notes, in some cases by several months. An action plan and some additional administrative resource have been put in place and the backlog is reducing. The local authority is also currently advertising to secure additional IRO resource. The Children and Families Advisory and Support Service (Cafcass) and IROs report improving communication more recently. Although IROs are confident that children who need an Independent Visitor receive this service, the use of the service is low, with only seven children and young people receiving this service in 2013–14.

67. Not all children and young people spoken to by inspectors knew how to make a complaint or how to access the advocacy service.

68. Headteachers who spoke to inspectors noted that there have been clear improvements in the support provided by the virtual school for children looked after since Hampshire managers joined the local authority. The new Virtual Headteacher, who took up post in September 2014, is being supported by a senior manager from Hampshire and this has brought an appropriate focus on improving the quality of personal education plans (PEPs). Training is planned on this for designated teachers later in the autumn term.

69. Children's chances of attending a good or outstanding school is an area of challenge for the local authority, given the general profile of schools on the island. Currently, half of the children looked after attend schools rated good or outstanding. The role of the social care education professional (SCEP) has been developed to support educational attainment for children looked after. The SCEP is integrated in the children looked after team and works to maintain focus on children's educational progress and outcomes. One foster carer was effusive about the role of the SCEP in supporting children placed with her into school. The children settled well and have made good progress and are now achieving in line with national expectations.

70. The Virtual Headteacher has prepared a comprehensive data book on educational achievement for children looked after, but this does not include data from the Early Years Foundation Stage (EYFS). The latest outcomes in the EYFS show improved performance on the previous year for children looked after in this age group, as was also seen for all Isle of Wight Reception children in 2014.

71. The 2014 data shows stronger outcomes at Key Stage 1 than Key Stage 2 (but, due to the size of the authority, numbers in all cohorts are small and can skew percentage outcomes). At Key Stage 1, three out of four pupils achieved the expected Level 2+ in reading and in writing and all four achieved Level 2+ in mathematics. At Key Stage 2, only half or fewer gained the expected Level 4+: three out of six in reading and writing, and two out of six in mathematics. The 2014 results for Key Stage 4 at GCSE level are poor, with no students (out of 19) gaining five GCSE A*-C grades including English and mathematics.

72. More positively, exclusion figures have been reducing. In 2013, they were broadly in line with national figures. The outcomes for 2014 show a further slight improvement in the number of days lost per pupil and the incidence of multiple exclusions. The data on the attendance of children looked after shows clear improvements since 2010, but the latest validated data for 2013 shows a 7.8% absence rate for children looked after. This remains higher than similar authorities at 4.2% and the national average of 4.4%.

73. Children's views have had an impact on some of the health services they receive. As a result, medicals are no longer conducted at school and the looked after children nurse is undergoing training in immunisation so that she can provide a more holistic service. Not all children benefit from prompt assessment of their initial health needs: in the first quarter of 2014–15, only 67% were completed within the 28-day timescale. This is lower than the last annual figure for statistical neighbours and England at 87% and 85%, respectively. The number of review health assessments completed in time is improving, with 75% within timescales in August 2014 in comparison with 52% in 2012–13. Only 78% of children looked after are registered with a dentist. The local authority and the CCG have recognised issues over access to Child and Adolescent Mental Health Services (CAMHS) and there are plans to revise the current service level agreement to address these.

74. The Fostering Team has made steady progress since January 2014 and foster carers' report being happy with the support offered by their supervising social workers. Recruitment, preparation and assessment of foster carers are working well, with assessments demonstrating increasing analysis. Training is strong and statutory checks and references are completed. Approved carers are visited regularly and see and sign supervision records. Carers understanding and use of delegated authority are underdeveloped, with not all foster carers being provided with clear written delegated authority for the children they care for. The use of stability meetings and weekly meetings with Leaving Care, ISS, Adoption and CiC teams are supporting the improvements in quality across the service and are building positive working arrangements across teams.

75. Some statutory visits to foster carers are being undertaken by unqualified staff. The vast majority (90%) of annual reviews are completed on time but the format and quality has been poor. This has been reviewed by the fostering manager and arrangements have recently changed, with the British Association for Adoption and Fostering (BAAF) review format being used from the end of September 2014. There is now a clear process for managing allegations and complaints and evidence was seen in one case looked at by inspectors of this being well managed. Allowances for foster carers were increased this year to be in line with the Fostering Network recommended payment and there is a comprehensive skills-based fostering scheme being developed alongside a linked training programme. This is due to go live at the end of January 2015.

76. There have been up to 30 enthusiastic children and young people who have been engaged in working with the local authority to improve outcomes for children and young people. There is an established CiCC, with up to six children and young people attending the six weekly meetings. Some young people have also attended the All Party Parliamentary Group on children looked after. Further work is needed to ensure that the CiCC is supported to involve and represent a wider range of children and young people. Young people are involved in interviewing staff, annual 'Have Your Say' days are used as consultation events; in 2013, this was used to develop the Pledge with young people. As a result of consultation with young people at this year's event, the local authority is developing a series of guides to support children and young people engaged with children's social care services. Children and young people spoken with by inspectors were not all aware of their entitlements.

77. Since April 2014, children aged eight to 12 have been able to attend Kids in Care Klub (KiCK). This is a positive development that provides fun activities and opportunities for consultation with younger children and prepares children to move on to the CiCC when they are older. A newsletter was produced at the start of October 2014 for all children looked after, and the participation officer uses Facebook to communicate with children and young people over 13. The annual STAR awards celebrate children's achievements.

78. A corporate parenting panel is in place, but demonstrates limited impact on services and outcomes for children. Although there are links with children looked after, their voices could be strengthened to inform the work of the panel. The panel is made up of a group of elected members and will be chaired by the new Lead Member. However, wider engagement with elected members is underdeveloped and there is no training or induction for members in relation to their role as corporate parents. This limits their effectiveness and ability to champion the needs of children looked after.

79. Appropriate strategic plans are in place to meet placement sufficiency needs and good progress has been made in implementing these. However, sufficiency of adopters is not included. The Fostering Team has a clear marketing strategy for 2014–15. This was launched in May 2014 and is on target to recruit 20 new fostering households in the current year, with 10 currently approved and seven being assessed. Further targeted recruitment will aim to meet specific needs, including sibling groups and teenagers. The Placement Officer is able to ensure that placement needs are met currently, but further capacity would allow more choice in matching.

80. Twenty children are currently in independent fostering agency (IFA) placements and there are good working relationships with local providers. Two local private residential providers are used and are broadly sufficient for local needs except when education is also required. The sufficiency strategy includes working with local providers to consider developing provision that also offers education. This would benefit those children who currently have to leave the island for such provision. The local authority would benefit from more detailed data and analysis on changing need. This is currently monitored each quarter, but in a very basic way.

The graded judgement for adoption performance is that it requires improvement

81. The Isle of Wight adoption team has remained stable during a time of wider poor performance. The appointment of a specialist adoption team manager in May 2014 has improved the oversight, scrutiny and quality of statutory social work in the team, particularly in relation to children looked after. Plans and timescales are tracked in regular social work supervision, but there is little evidence of analysis or reflection within these records.

82. One of the key reasons the adoption performance is not yet good is because it has not been consistently prioritised in strategic or corporate thinking. This is illustrated by the limited reference to adoption within the sufficiency duty statement and the absence of an adoption marketing budget or strategy. The Statement of Purpose and Function for the Adoption Service has not been updated since 2011.

83. The rate and percentage of children being adopted in the Isle of Wight is relatively low. Eight per cent of children looked after were adopted in 2013–14. This is less than the national average of 17% and the statistical neighbours' average of 20%. In 2013–14, seven children were adopted, one more than in the previous year but eight fewer than in 2011–12. Inspectors did not see any cases where adoption should have been considered for a child, but had not been.

84. Adoption is considered for all children who cannot remain with their birth families, alongside other permanence options such as special guardianship orders (SGOs). Over the past six months, the consistent engagement of the adoption team in legal strategy meetings and permanency planning meetings has led to a sharper focus on parallel planning and early family finding. In 2013–14, 21 SGOs were made compared with six in the previous year.

85. The local authority's performance measured against the 2010-13 adoption scorecard compares favourably with national figures. The average number of days between children entering care to being placed with an adoptive family, at 629 days, is better than the national average. However, it is 59 days longer than statistical neighbours. Once the court has agreed that a child can be placed for adoption, a family is found relatively quickly. In 2010-13, this took an average of 142 days, an improvement on the previous period and better than the national average of 210 days.

86. At the time of this inspection, 17 children were waiting to be adopted. Of this group, seven had already been matched and placed with a family and were awaiting an adoption order and four had been found a family but were not yet placed. A comprehensive monthly report on all children waiting for adoption is sent to senior managers and this is used to oversee and scrutinise family finding and timescales.

87. In 2010-13, the local authority was successful in having 7% (15) of their children who were adopted being aged five and over. This compares with 4% for England as a whole. Of the 10 children who were matched with adopters within the three months preceding this inspection, five were age five years or over and eight have been found families where they will live with their brothers or sisters. Some have very complex needs. This is positive for individual children and, although there was no unnecessary delay, finding families for these children often takes longer, which inevitably affects scorecard performance.

88. In the past 12 months, family finding activity has been broadened and strengthened. However, activity days have not been used and the local authority has not placed any targeted advertisements in non-adoption publications. Concurrent planning has not been used and the authority is also yet to introduce a formal 'fostering to adopt' scheme. The service is now placing Isle of Wight children with local adopters after careful consideration of the potential risks.

89. The Adoption Reform Grant and income generated through providing adopters to other local authorities have primarily been used to purchase adoptive placements. In line with government guidance, the Adoption Reform Grant should be invested more creatively to further improve the effectiveness and sustainability of the service.

90. In 2013–14, there were 25 enquiries from potential adopters, with eight families being approved, including a same sex couple. In the six months prior to this inspection, there were just seven enquiries. In 2013–14, statutory assessment timescales were not met for most adopters who were presented to panel and, although adopters are generally positive about the service, some express frustrations about the relative slow speed of the early stages of the assessment process.

91. Experienced and enthusiastic social workers speak knowledgeably and affectionately about children and their adoptive parents and, in cases seen by inspectors, adopted children were happy and settled. Records of visits to children include observations and sensitive discussions with carers, but inspectors saw two cases where statutory visiting timescales had not been met or children had not been seen alone.

92. Social workers report that they have good access to CAMHS and are able to spot purchase an independent therapist, however there is no ring-fenced therapeutic time available for adoption related consultation or direct work. In one case seen by inspectors, earlier therapeutic support would have helped adopters to better understand the child's attachment needs prior to placement.

93. Life story work is undertaken for children with a plan of adoption and photographs and mementoes of their birth families are included. However, there are not enough photographs of the time spent living with foster carers and life story work is often not overseen by social workers. Foster carers create memory boxes for children, but they are not always combined into one record and for these children their life story book is incomplete. This was highlighted in the inspection of the adoption service in 2011 and has not yet been fully improved. Later life letters are warm and detailed and final contacts with birth parents are described particularly well.

94. The adoption panel is well managed and administrated and new members have been appointed to ensure a wider range of experience. Legal and medical advice is clear and adopters are able to meet with the medical adviser to discuss any health-related questions. Decisions made by the Agency Decision Maker (ADM) are timely and they evidence appropriate challenge. Panel members provide useful feedback, but this is not analysed or disseminated, which limits its impact. The quality of reports presented to panel has improved considerably in the past six months, with good analysis and few areas of ambiguity. The work of the adoption panel is considered within the adoption annual report and there is a process for panel members and adopters to complete feedback forms about the panel. However, learning from these is not assimilated or shared to improve practice. There are no formal arrangements for the chair to meet with senior managers to discuss national developments and local issues. The panel has not received any training for two years and there is no involvement from local councillors in this important process.

95. Post-adoption support, which is being provided to nine families, is highly valued and there is no waiting list for support. One young person said her support worker, 'Helped me to talk to my mum and dad when I am upset,' and, 'I miss her, but I don't really need her any more'. An annual adoption support newsletter is sent to 90 families and fun days and activity events for young people are further improving links with local adoptive families. Adopters praised the specialist parenting course run by Barnado's. Post-adoption support plans include needs and sources of support, but are not specific enough, for example saying that 'therapeutic support' may be required.

96. In 2013–14, 100 children were involved in indirect letterbox contact, and parents with learning needs are helped to write to their birth children. Last year, 17 adult adoptees were provided with birth records counselling. Inspectors saw good examples of support to birth parents, and social workers are encouraging parents to think about their future choices. Careful preparation enabled one father to meet his child's adopters, saying that the meeting had helped him to, 'Find closure,' and that, 'You have chosen a great family for our boys'.

97. The recording system used by the adoption team is not fit for purpose. There is an overreliance on paper files, and the use of two electronic systems is confusing and time consuming. There is no secure electronic system for case files and, although managers are aware of this, an electronic solution has not yet been commissioned.

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

98. The leaving care team was established in December 2013 and was fully staffed in March 2014. Prior to the establishment of a dedicated team, provision was through generic teams and the support for care leavers was of a poor quality. In developing a team, the local authority has benefited from the partnership with Hampshire County Council in terms of joint training and peer support.

99. The team manager has substantial experience of working with older teenagers and a number of the personal assistants, whose workloads are manageable, have transferred to the team from the youth service. This has enabled the leaving care team to develop appropriate systems and establish clear relationships with care leavers.

100. Supervision and case management of practitioners is regular and clearly task-focused; self-evaluation is accurate. Provision in the past has led to a degree of disenchantment from a number of older care leavers. Personal advisers are working hard to overcome this and, generally, care leavers do recognise the improvement in support provided by the leaving care team. Overall, however, there remains much to do to ensure that systems and procedures are robust, effective and measure impact.

101. A particular and appropriate focus for the team is to provide stronger support for young people at times of transition and, in particular, as they reach the leaving care stage. To support this there is a developing link with the use of pupil premium funding for children in care through the virtual school.

102. Pathway plans have been re-modelled and re-issued to care leavers. These are up-to-date and of a good quality. This was a substantial piece of work for the leaving care team during the summer and all plans have been monitored and signed off by managers. The new plans offer clear targets based on discussions with young people and include practical consideration of a 'Plan B' that can be considered if appropriate. Care leavers generally felt that their new plans were an improvement on previous documents and agreed that, along with the support from personal advisers, these helped them to review choices and opportunities. As these plans are so new there is still some way to go to ensure that there is consistent impact following implementation. In addition, the team has just started preparing pathway plans for care leavers with disabilities. Again, it is too early to assess their impact.

103. The service has only recently started to use impact data to measure the outcomes for care leavers and to use this to develop plans to improve provision. Monthly performance management monitoring considers the proportion of care leavers at various ages who are not in employment, education or training or suitable accommodation and who have a current pathway plan. However, this greater monitoring is yet to develop sustained and consistent improvement in outcomes for all care leavers.

104. Care leavers report that they have safe accommodation and have some choices about where they live. These choices include supported accommodation and the independent rental sector. The local authority has a focus on developing provision for 'Staying Put' as a choice for young people. Currently there are just four care leavers accessing care under the scheme. This procedure includes keeping placements open to care leavers who are attending university or higher education institutions, but this is still in development.

105. Data trends over time show that the local authority has increased the proportion of care leavers aged 19 who are in suitable accommodation to around 90%. However, there remain two young people who are in bed and breakfast accommodation; for one young person this had been the case for three months, with a meeting with a housing association arranged only recently. Eight young carers are also living in houses of multiple occupancy. One care leaver is in custody and there are two young people who are in irregular contact with members of the team and whose current living arrangements are unknown.

106. There is provision for young people to take part in training for greater independence, with opportunities for budgeting, cooking and maintaining healthy lifestyles. Health information and signposting of universal and specialist health services are available for care leavers. The specialist nurse for children looked after liaises with personal advisers regularly and attends meetings to discuss individual support. Although care leavers noted that they had access to appropriate medical and dental services, health professionals stated that it can be difficult to secure the appropriate support for mental and emotional health. Senior managers are aware of this and there is currently consideration of a new service level agreement between the local authority and health service to include improved specific support for mental and emotional health for care leavers.

107. The named midwife for safeguarding children supports care leavers who are pregnant. For those who are parents, support is offered through local children's centres.

108. Care leavers are part of the children in care council and they have been instrumental in developing improvements such as the increase in the leaving care grant and other practical improvements such as a dedicated noticeboard with contact details in the reception area at County Hall. Care leavers also took part in a 'Have your say' event during the summer, providing their views on how to improve the service. However, care leavers spoken to were unsure of the care leavers' pledge or their entitlements. They can communicate through a Facebook group, with around half of all care leavers (40-50) linked to this facility.

109. There is a group of young people who are interested in peer mentoring and two care leavers were trained and received accreditation for this in April. More training for six young people is planned for October. However, currently there are no care leavers involved in peer mentoring, which is a missed opportunity.

110. The performance data in relation to care leavers in employment, education or training is variable. Following an improving trend over the last few years and strong performance in 2012, the data for 2013 shows outcomes that have fallen below similar authorities and the national average. The most recent data for July and August shows some improvement, but out of 110 care leavers, 37 are not in employment, education or training. For 20 of these young people, this is due to illness or being full time parents of young children. The number of care leavers undertaking university level courses has improved slowly over recent years and is currently a cohort of nine young people.

111. The local authority has introduced an effective pilot project for supporting care leavers into employment - called the '123 Programme'. This provides support care leavers at a variety of levels and culminates in apprenticeship opportunities within the council and other local employers. In 2013, four care leavers were selected for the project, with successful outcomes including full-time employment and continued study in further education.

Key judgement	Judgement grade
Leadership, management and governance	Requires improvement

Summary

The local authority now has a thorough knowledge of the issues affecting children, young people and their families in the area and a clear understanding of the effectiveness of services that are provided to support them. A self-evaluation by the local authority children's services in June 2014, together with monitoring reports, provide a realistic analysis of the work undertaken to tackle the deficits identified in the Ofsted inspection in 2012 and the significant further work required to improve services to a good standard.

The Isle of Wight Council and Hampshire County Council have established an effective strategic partnership. Clear lines of reporting and accountability have been agreed between the two councils that ensure timely decision making and an effective oversight of services. This creative, sector-led model for improvement is beginning to lead to improvement in the quality and reliability of services to children and families. However, it is too soon to evidence a consistent impact on improving quality of practice and outcomes for children.

Senior managers are aware of the ongoing and remaining challenges to improve services, establish effective management and achieve consistently good practice. Substantial progress has been made from a very low base, particularly over the last six months. They rightly recognise that it will take a large amount of time and energy to systematically implement and embed the changes in structure, staffing, practice and culture in order to raise and maintain standards to a good or higher level.

Areas for further improvement include addressing management capacity and skill and ensuring that the ICS is a fully effective tool for social workers and managers to oversee case work and decision making for children. Elected members need to become more engaged in the effective scrutiny of services, developing the role of corporate parenting across the authority.

112. Effective governance arrangements are in place to ensure that senior managers and independent chairs work together to achieve improvements across children's services. Clear lines of communication have been established, including regular meetings between the Managing Director (MD – the head of paid service for the Council), the Director of Children's Services (DCS), the Deputy Director (DD) and the chair of the Local Safeguarding Children Board (LSCB).

113. The DCS, the Deputy DCS and MD consistently attend the Children's Improvement Board (CIB) and they also have regular dialogue with the chair of CIB. Discussions are timely and effective and enable the MD to seek the support of the political leadership when required, for example to secure funding for an additional children in need team.

114. The MD, Lead Member and Area Director routinely attend the Health and Wellbeing Board. The Children's Trust was reviewed and re-established in January 2014 and provides stronger oversight of matters affecting children, including health. There is a clear joint working protocol between the Trust, the LSCB and the Improvement Board, with safeguarding reports to the Health and Wellbeing Board to ensure that children's issues are considered. There has been a very recent change in the Lead Member for Children's Services following a realignment of the Executive Cabinet positions. At the time of inspection, the new Lead Member was actively gaining an overview of current issues across children's services and is assuming full responsibility with immediate effect with support from colleague members and officers.

115. The Joint Strategic Needs Assessment was revised in 2013 and sets out clear local priorities. However, it does not reflect the subsequent and major structural and service changes across partner agencies and their changing priorities.

116. Arrangements for the robust scrutiny of children's services are underdeveloped. For the past six months the focus for local authority's scrutiny committee has been limited to financial matters and updates from the children's improvement board. The scrutiny of matters affecting children looked after is ineffective as these have not been considered for at least six months. The local authority recognises that their current council scrutiny model is not sufficient and a decision has very recently been taken to establish select committees, including a single committee dedicated to Children's Services, but these are not yet in place.

117. Corporate parenting is also an area that requires further development in order to be effective. A corporate parenting panel is established but has had limited impact on services and outcomes for children looked after. A young person regularly attends the panel alongside a range of professionals, including the Virtual Headteacher, Looked After Children's Nurse and a service manager from children's social care. Three elected members also sit on the panel, including the new Lead Member who will chair the group. However, there is little engagement from the wider group of elected members in undertaking or understanding their role as corporate parents. No training or induction has been provided to elected members on this issue. This is acknowledged by the group as an area for development and the new Lead Member has plans to engage children and young people more meaningfully within the panel and to reinvigorate corporate parenting more generally in the council to raise the its aspirations for looked after children and care leavers.

118. The range and quality of performance information within children's services has seen substantial improvement in 2014 and this continues to be developed. Key data, agreed by senior managers and strategic boards, is routinely collated and reported to managers, the LSCB and the Improvement Board. A brief analysis of data, including the trends and issues arising, is provided by service managers and directors. This is used to develop services and to target audit activity. Operational managers receive regular performance information on the activity within their teams. However, this is not yet consistently used by team managers to monitor and manage the quality of work within their teams.

119. Regular monthly audits have been conducted by managers across children's services since January 2014. The collated findings are reported to senior managers and strategic boards such as the LSCB and the Improvement Board. Findings on individual cases are reported to team managers and social workers to help improve practice. Recurrent themes have resulted in a management direction to improve practice. Audit tools and methodology have been adopted from Hampshire processes, but audits are not consistently robust as many managers lack experience in undertaking them. Senior managers have discussed the need to provide training to support team managers with their audit work, but this has not yet taken place. Audits have initially primarily focused on compliance, in order to raise baseline practice standards. The key issues and themes identified in the audits the local authority undertook for this inspection were issues that had previously been identified in their own audits. Although audits have shown gradual improvement, some areas of poor practice persist, such as first line management oversight, recording and the limited use of chronologies.

120. Management oversight of practice has increased and improved in the past six months, from a low baseline. Senior managers are involved in case audits and services managers are actively engaged in overseeing practice, for example in endorsing all child protection enquiries. Staff value the accessibility of managers, but service managers are under significant pressure and are undertaking extensive and unsustainable direct operational input into teams while team managers are being supported to develop their skills.

121. Most team managers are recently appointed and have limited management experience. Senior managers recognise the challenge of ensuring that all team managers are competent and consistently provide high quality leadership and management. A training programme for team managers provided in January 2014 was not sufficiently effective for some. Further targeted training has been recently provided, but it is too early to see the impact of this.

122. Supervision processes, adopted from Hampshire, introduced in January 2014, have begun to improve the structure and recording of supervision. However, supervision records do not consistently evidence that supervision is regularly provided to social work staff or detail clear direction and actions required. Few evidence any reflective discussion. All workers seen spoke positively about the support, supervision and accessibility of their team and assistant team managers.

123. Extensive work has been undertaken by the local authority to address 82,000 electronic documents that historically were not recorded in children's electronic files on the ICS. Most have now been uploaded, with work continuing to upload the remaining 17,000. However, many case documents are still stored in different parts of the children's services electronic recording system. Too often, documents are not readily accessible to social workers and managers to enable effective case working and oversight of cases.

124. Partnership work has improved significantly over the past year. This has been enhanced by the open approach of senior managers, who have communicated and engaged well with partner agencies to strengthen relationships. As a result, partners have a clearer understanding of the changes being implemented in the local authority and this has enabled more open discussions to begin in relation to the development of joint working and the joint commissioning of services.

125. Commissioning of early help services has been underpinned by rigorous analysis of need and evaluation of the impact of current provision. Commissioning processes are transparent and have encouraged wider engagement of the private and voluntary sector. The commissioning of targeted provision to meet higher level needs and the joint commissioning of services with partner agencies is underdeveloped. This is recognised by senior managers and a range of strategic and operational groups are being used to understand each agency's current commissioning activity and to consider more effective individual and jointly commissioned services for children and their families.

126. Transition services are now managed within adult services. Individual young people with complex needs are assessed to determine who may require support from adult services. Some good examples were seen of multi-agency work to support the complex transition of young people, in particular those with a disability. However, managers recognise that they are at the very early stages of strategically reviewing, developing and commissioning a full range of services to systematically meet the diverse needs of young people requiring support in their transition to adulthood.

127. Private and voluntary sector representatives from larger agencies are actively engaged in a range of strategic and working groups that enable them to contribute to the development of children's services. The sector provides an extensive range of services that support children and families and representatives report that they are treated as equal partners and are readily able to raise or escalate concerns.

128. Improvements in the use of the legal planning process and in the use of the PLO have been noted from mid-2014, following discussions with legal services and the involvement of service managers. This has resulted in greater consistency in decision making for children where court intervention is necessary. However, Children's Services are not regularly represented at the Local Family Justice Board and as such do not make sufficient contributions to the work of the Board or ensure that issues specific to the Isle of Wight are considered. There has been undue delay in developing a pre-proceedings protocol across the four local authority groups (with Hampshire, Portsmouth and Southampton). The Judiciary, Cafcass and legal representatives report concerns that some cases that should have been put before the courts have been held too long within Children's Services.

129. The local authority has taken extensive action to secure a stable, competent and sufficient workforce, which has posed a major challenge, in part due to the island location. The Children's Services recruitment and retention strategy is still in draft form. It details a wide range of measures that have been particularly effective in recruiting new social work staff and reducing previous over-reliance on agency staff. While this has resulted in the recruitment of a high number of newly qualified staff (17 since the previous inspection) the number of experienced social work staff is low in relation to the number of complex cases which need to be allocated. As a result, many of the experienced social workers have, until recently, held caseloads which were too high. For a small number of social workers, their case loads remain too high. This negatively affects practice. Managers are monitoring caseloads regularly and caseloads are now slowly reducing.

130. The local authority supports newly qualified social workers well and is proactive in developing potential social workers through a regional commitment to the 'Step up to Social Work' programme. Strategic guidance in relation to workforce development was introduced in July 2014. This provides a clear synopsis of current and future initiatives and the priorities for staff undertaking development programmes. It is too early for this to demonstrate an impact.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement
The arrangements in place to evaluate the effectiveness of what is done by the authority and board partners to safeguard and promote the welfare of children require improvement.

Summary of findings

The LSCB requires improvement because:

- Although the LSCB is now being chaired effectively and positive steps are being taken for the board to undertake its full role, it is too soon to evidence the recent positive impact of the board's work on improving outcomes for children.
- The LSCB does not yet have a detailed understanding of the quality of multi-agency practice with children who have been identified as being at risk of significant harm.
- The LSCB does not yet have a full understanding of local need, particularly around adult mental ill health, domestic abuse, substance misuse and neglect.
- The newly utilised performance framework and the scrutiny of partnership performance is not yet embedded, and the use of the comprehensive multi-agency data to improve safeguarding is still at an early stage.
- The LSCB work plan does not address key issues such as engagement of the faith and voluntary sector, safer recruitment, bullying and e-safety.
- The LSCB does not have a full understanding of the needs and issues for children who go missing, including those who are at risk of child sexual exploitation, as return interviews are not routinely undertaken with children on their return and analysis of these interviews is not undertaken.
- The work to identify and raise awareness of privately fostered children on the island has not been effective.
- The LSCB is not yet evaluating the impact of its training on practice.
- The LSCB's engagement of young people to understand their experience of safeguarding in order to evaluate improvement is at an early stage.

What does the LSCB need to improve?

Priority and immediate action

There are no priority actions.

Areas for improvement

Quality assurance, data and performance

131. Evaluate the quality of multi-agency partnership work with children at risk of significant harm on a continuing basis and use the learning to drive improvement.

132. Develop an understanding of local need from data, particularly in respect of adult mental health, substance misuse, domestic abuse and neglect. Use this to determine LSCB priorities and to scrutinise the work of other strategic partnerships.

133. Consolidate the existing use of multi-agency data to analyse trends and performance and to identify key areas for improvement.

134. Ensure that the LSCB gains a clear understanding of the reasons why children go missing to identify trends and patterns and improve service response to those who go missing, including those young people at risk of child sexual exploitation.

135. Strengthen the engagement of and consultation with young people in the Board's work so that children's experience can inform developments and be included in the evaluation of improvement.

Governance

136. Develop robust links with the Family Justice Board to scrutinise the safeguarding of children in public and private law proceedings.

137. Strengthen the LSCB's scrutiny of public protection arrangement on the Isle of Wight, particularly in respect to the MAPPA and MARAC.

Development of key areas

138. Raise awareness of privately fostered children on the Isle of Wight among agencies and the community.

139. Deliver a multi-agency training programme based on the outcome of the training needs analysis and develop mechanisms to evaluate the impact of training on practice.

140. Strengthen the work of the voluntary sector and the faith sector and ensure that the partnership has clear advice and guidance around safer recruitment.

141. Develop work regarding e-safety and ensure that principles of safe practice and guidance for children and their parents are used across the partnership and community.

142. Review the effectiveness of the Child Death Overview panel (CDOP) in identifying modifiable cases of child death and implementing learning.

Inspection judgement about the LSCB

143. The Isle of Wight LSCB started from a very low base. The LSCB was judged by Ofsted in December 2012 to be underdeveloped, failing to meet statutory requirements and ineffective in providing oversight of child protection work on the island. A new Chair was appointed and the Board was reorganised from October 2013 and it has made sustained progress on all fronts.

144. The Board now meets statutory requirements in most areas and the partnership has become increasingly robust and effective. The majority of the areas for improvement identified in this review already form part of the Board's existing work plan or are at an advanced stage, but have not yet had time to be fully embedded. The financial foundations of the Board are sound, with a proportionate contribution made by the main statutory agencies.

145. The LSCB Chair provides strong leadership and challenge to agencies. The membership of the Board meets statutory requirements and Board members are of appropriate seniority to deliver change. There is an interim Designated Doctor in place while recruitment is underway. A Lay Member has been appointed recently and the Board is in the process of recruiting a second. However, there have been difficulties engaging schools representatives to sit on the Board. A secondary school head teacher has only just joined the Board.

146. The LSCB Chair is held to account by the Managing Director in line with statutory guidance. The LSCB reports in to the Children's Improvement Board (CIB) and contributes to the Improvement Board's work and agenda. In part, because the LSCB is now in a stronger position to undertake the oversight, scrutiny and development of safeguarding work, the frequency of CIB meetings is now reducing.

147. The LSCB has made progress in strengthening the partnership and holding partners to account. The Board now keeps a challenge log to monitor progress on actions identified. There is a protocol in place between the LSCB, the Children Trust Board and the Health and Wellbeing Board. The influence and impact of the LSCB on these forums is beginning to be evidenced through, for example, the collaboration with the Children's Trust on revising the thresholds document in May 2014 and the LSCB support for the anti-bullying conference held in October 2014. The Board has no developed links with the Family Justice Board, which means that the LSCB has not met its statutory function and exercised oversight and scrutiny of the safeguarding of children subject to public and private law proceedings.

148. Although data is reported to the Board by the MAPPA and MARAC, an analytical annual report has not yet been provided to enable the Board to scrutinise risk management in the public protection arrangements on the Isle of Wight. This is however on the forward plan and there are plans for this to be completed later this year.

149. The LSCB published a three-year Strategic Plan within which it set out early priorities, on which it has made significant progress over the last twelve months. These priorities are driven by effective sub-committees, chaired by senior managers from across the partnership. The priorities and work plan however, concentrate on establishing basic foundations and do not sufficiently address broader issues of adult mental ill health, substance misuse and domestic abuse or neglect. In addition it does not address key issues of local need around teenage pregnancy and alcohol abuse. The work in relation to the faith sector is also underdeveloped, as is safeguarding among smaller voluntary organisations on the island. There is also work to do to ensure that partner agencies have clear guidance in relation to safer recruitment practice and standards, and to promote e-safety across the wider partnership.

150. The Board has developed a multi-agency data set that was used for the first time in September 2014 to analyse trends and assess performance. The data set helps the Board to understand social care and NHS Trust performance well, but currently provides insufficient focus on the performance of partner agencies. There are also still data gaps from CAMHS, Adult Mental Health and Probation. Key data around the prevalence of adult mental ill health and substance misuse has not been fully considered by the Board. Although the database is an important step forward, it is too recent to have influenced the priority setting of the LSCB and data and further analysis are required to provide the Board with a good understanding of local need.

151. The analysis of data is being used very effectively to identify key lines of further partnership work to safeguard children, but this is still at a very early stage and too soon to demonstrate impact.

152. The annual report provides a transparent evaluation of safeguarding. However, limitations in available data reduce its capacity to challenge and influence other key strategic partners.

153. The Board has completed four multi-agency audits into early help, child protection, section 47 enquiries, and children in need. As a response to the learning from the children in need audit, the LSCB published the Children in Need strategy and a revised threshold document. This demonstrates how the Board has used learning from audit to evaluate the effectiveness of early help and bring about improvement. The threshold document was re-launched in early summer 2014 and is understood and valued by partners. Professionals reported that they have found this helpful in reducing the number of high risk cases being held within early help services and it has also helped to clarify thresholds into children's social care.

154. This audit programme is still too recent to fully inform the work of the Board. For example, the Board has not yet completed the analysis of the section 47 audit and therefore does not yet have a good understanding of the quality of multi-agency work for children at risk of significant harm. The Board currently relies on the single agency audits provided to the Improvement Board, which do not evaluate partnership work and are focused on compliance rather than quality.

155. The Chair of the Board has encouraged Board Members to carry out 'walkabouts' in front-line services and this has helped raise awareness for board members about safeguarding in these services. This initiative has also highlighted to the Board partnership issues that needed attention, such as improved discharge planning between children's social care and the hospital. It has also highlighted the need for more multi-agency safeguarding training for front-line staff to ensure that they fully understand processes and procedures regarding joint work.

156. The Board audits consider whether agencies consult children as part of service development and are building the consultation of children into the current section 47 multi-agency audit. Despite this, consultation with children in relation to safeguarding services is still at an early stage. Children do not currently contribute to the development of the LSCB priorities, Board meetings, or specific pieces of work led by the Board such as e-safety work or anti-bullying. It is too early to see how children's experiences of services have been used as a measure of improvement.

157. A robust section 11 audit has been completed by all Board partners and is now being extended to GPs. This has identified a number of areas in which agencies need to improve. Two agencies have not yet submitted their section 11 reports – Adult Services and HMP Isle of Wight. The Board has appropriately challenged these bodies.

158. The LSCB has published a range of good quality safeguarding policies that are kept under review and updated. These include policies on honour-based violence, domestic abuse and working with parental mental ill health. The effectiveness of these policies is evaluated through the multi-agency audits and learning from partnership reviews.

159. In 2013, a low number of multi-agency training courses were delivered and the LSCB training budget was underspent. Following the arrival of the new Chair, the Board joined the Hampshire Workforce Development Subgroup and an interim package of training was delivered in 2014 that focused on lessons from serious case reviews (SCRs) and on neglect. This has reached over 500 members of staff and was drawn from immediate priorities. A systematic multi-agency training needs analysis is currently in progress and has identified a number of key gaps in current provision, for example child protection work with disabled children, the impact of parental domestic abuse, adult mental ill health and substance misuse. This means that the training needs of the children's workforce have not been sufficiently met to date. Neglect was also recognised during this analysis resulting in training being delivered in June 2014 with the issue now identified as an ongoing priority. The Board evaluates feedback from training events, and although it has been piloting a new method of impact analysis since June 2014, it is not yet able to evaluate the impact of training on practice that is part of their statutory function.

160. The LSCB is aware of the low number of privately fostered children identified in the area. In May 2014, the Board implemented an action plan to raise awareness in the community and partners, but this has yet to take effect. There was little awareness-raising work with partners or the community undertaken last year on this issue. There is currently just one privately fostered child known to the local authority.

161. Arrangements for monitoring children who are missing from education are robust. The LSCB Education Subgroup records data on children who are missing from education and ensures that they robustly review each case. Of 115 children missing from education in 2013–14, there is just one child whose case is still open. There are processes in place to monitor children missing from home or care and for those placed outside the local authority area. These children are tracked and discussed at the METRAC and a plan is put in place to reduce the incidence of missing episodes. The METRAC reports data to the Performance and Quality Assurance Subgroup.

162. The LSCB oversight of children who are at risk of child sexual exploitation is strong. It has recently developed a profile of child sexual exploitation in its area and operational information sharing at the METRAC is being used to track known perpetrators. A risk assessment tool has been developed and awareness of child sexual exploitation is being promoted with agencies and in schools. The production 'Chelsea's Choice' has been shown to 1,500 secondary school children in a secondary school population of around 6,000.

163. With the arrival of the new LSCB Independent Chair, the threshold for convening an SCR is now applied in line with statutory guidance. The SCR Sub-committee is now effective in reviewing cases and identifying learning and is robust and thorough in tracking actions from current and past SCRs. A series of 'Learning Lessons' events have been launched and have reached over 350 people. A number of professionals told inspectors that this had raised awareness, had helped to improve their understanding of multi-agency work and had strengthened inter agency relationships.

164. The CDOP is shared with three other local authorities in order to provide a regional overview of child death. However, the rate of modifiable deaths reported in the Annual Report 2013–14 is just 9%, which is less than half of that of statistical neighbours (between 20–24%) and England (22%). Minutes seen indicate that some cases are not deemed modifiable because there is insufficient information available at the panel. This indicates that the CDOP is ineffective in identifying learning from all the cases. In addition, the CDOP report does not demonstrate a robust link between learning and action taken to reduce infant mortality rates locally and has not run any public health campaigns for some time. To address this, a regional meeting has been organised to identify the appropriate additional actions the CDOP can take in response to learning from cases.

What the inspection judgements mean

The local authority

An **outstanding** local authority leads highly effective services that contribute to significantly improved outcomes for children and young people who need help and protection and care. Their progress exceeds expectations and is sustained over time.

A **good** local authority leads effective services that help, protect and care for children and young people and those who are looked after and care leavers have their welfare safeguarded and promoted.

In a local authority that **requires improvement**, there are no widespread or serious failures that create or leave children being harmed or at risk of harm. The welfare of looked after children is safeguarded and promoted. Minimum requirements are in place, however, the authority is not yet delivering good protection, help and care for children, young people and families.

A local authority that is **inadequate** is providing services where there are widespread or serious failures that create or leave children being harmed or at risk of harm or result in children looked after or care leavers not having their welfare safeguarded and promoted.

The LSCB

An **outstanding** LSCB is highly influential in improving the care and protection of children. Their evaluation of performance is exceptional and helps the local authority and its partners to understand the difference that services make and where they need to improve. The LSCB creates and fosters an effective learning culture.

An LSCB that is **good** coordinates the activity of statutory partners and monitors the effectiveness of local arrangements. Multi-agency training in the protection and care of children is effective and evaluated regularly for impact. The LSCB provides robust and rigorous evaluation and analysis of local performance that identifies areas for improvement and influences the planning and delivery of high-quality services.

An LSCB **requires improvement** if it does not yet demonstrate the characteristics of good.

An LSCB that is **inadequate** does not demonstrate that it has effective arrangements in place and the required skills to discharge its statutory functions. It does not understand the experiences of children and young people locally and fails to identify where improvements can be made.

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 8 of Her Majesty's Inspectors (HMI) and a contracted inspector from Ofsted.

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