

London Borough of Hammersmith and Fulham

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 Board¹

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Children’s services in the London Borough of Hammersmith and Fulham are good		
1. Children who need help and protection		Good
2. Children looked after and achieving permanence		Good
	2.1 Adoption performance	Outstanding
	2.2 Experiences and progress of care leavers	Good
3. Leadership, management and governance		Outstanding

¹ Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspections Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

Executive summary

Children's services in Hammersmith and Fulham are of a consistently good quality. Services are significantly enhanced by the innovative and highly effective tri-borough partnership with the City of Westminster, and the Royal Borough of Kensington and Chelsea. Economies of scale, achieved through shared administrative and managerial functions, have created opportunities to develop and deliver a broad range of highly effective and innovative services. This includes the 'focus on practice' initiative that clearly reflects the commitment of politicians, managers and the social care workforce to create an environment where good-quality social work flourishes and a 'culture of compassion', as described to inspectors, is evident. This leads to improved outcomes for the majority of children and young people. Sustained investment, to ensure that caseloads are manageable in all aspects of the service, supports this achievement.

Other tri-borough collaborations exist within the commissioning framework, where a dedicated specialist team operates to a well-established and highly coherent model, including joint commissioning. Tri-borough commissioners are highly active in shaping resources to meet need. They have very efficiently recommissioned some services, such as semi-independent living for care leavers. Similarly, performance management and quality assurance systems are well developed and are used effectively across the boroughs to maintain and improve performance. Exemplary workforce planning means that the tri-borough partnership generally has a stable and experienced workforce. Although Hammersmith and Fulham has a greater number of newly qualified workers, they are very well supported and additional funding has secured additional experienced locum support, if and when required.

The tri-borough partnership's Executive Director of Children's Services manages this complex set of arrangements extremely well. Robust governance within the borough ensures that senior managers have an accurate understanding of their service and that they address service deficits robustly. There is no complacency; there is, instead, a strong culture of continuous learning, professional accountability and responsibility. The care leaving service provides a good example, where the need for improvement has been addressed through considered planning and investment. However, the local authority scrutiny committee lacks sufficient focus on children's social care. It does not identify areas for development and considers performance management information too narrowly to be fully informed about the service. Further work is required to ensure that the health and well-being board takes greater account of children and young people's issues.

Children and their families are able to access coordinated, effective and timely early support from a broad range of universal and targeted services. If risks escalate, referrals are prompt and appropriate. Partner agencies have a good understanding of thresholds for referral, including the need to gain consent, where appropriate. When children are referred to children's social care, they almost always receive a prompt response that ensures that they get the services they need as soon as possible.

Social workers know children and young people well and the voice of the child is

valued. Assessments are generally of good quality and lead to planned interventions that make a positive difference. A minority of assessments and care plans for children looked after were not thorough or updated at points of significant change. Widespread access to the services of 'family assist', which supports children to remain with their families if possible, clinical teams and other specialist provision, has had a very positive impact on improving outcomes for many of the most vulnerable young people in the borough, including those on the cusp of care.

The use of evaluated models of practice has had a positive impact in focusing professionals to develop plans that are proportionate to reduce and manage risk. There is a clear process for parents and carers to know what changes are required. Further work is required to support children and young people to attend meetings that affect them. The widespread use of family group conferences promotes child- and family-focused solutions.

Decisions about whether children should become or remain looked after are timely and are based on evidence about the child or young person's needs. When necessary, care proceedings are initiated quickly to ensure that children are not exposed to harm for extended periods. Services for children looked after remain good, with almost all children and young people benefiting from stable and secure placements. The virtual school supports children looked after well, in all areas of their education.

The quality of the adoption service is outstanding. Adoption is considered for all children looked after, including those with complex needs. This results in excellent outcomes, with higher than average numbers from minority ethnic groups and children over five being adopted.

The care leavers' service has rapidly improved following restructuring and is now delivering good-quality services and support to young people. However, areas for development remain regarding the quality of pathway planning and support to young people who are not in education, employment or training.

The emergency duty service does not instigate child protection processes in a timely manner and is insufficiently resourced to ensure that children and young people are supported to be placed in foster care or with relatives 'out of hours'.

Children missing from home, care and education and those at risk of being sexually exploited are known and well supported. Return home interviews, although occurring, are not collated to identify patterns of behaviour to support proactive planning to reduce risk. Close working with the police ensures that measures to counter the risks posed to young people by radicalisation are effective and integrated into the broader range of services for families. Work to raise awareness of female genital mutilation and to identify those most at risk of the practice is highly innovative and effective. This has led to an increase in referrals to children's social care.

Good attention is paid to the identity and diversity needs of children in most parts of

the service. For children looked after and those requiring permanence, it is a particular strength.

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The local authority

Information about this local authority area²

Previous Ofsted inspections

- The local authority operates one children's home, which was judged to be good at its most recent Ofsted inspection.
- The previous inspection of the local authority's safeguarding arrangements was in July 2011. The local authority was judged to be good.
- The previous inspection of the local authority's services for children looked after was in July 2011. The local authority was judged to be good.

Local leadership

- The Director of Children's Services (DCS) has been in post since September 2011.
- The DCS is Executive Director of Children's Services for the tri-borough partnership, which comprises the City of Westminster, the London Borough of Hammersmith and Fulham, and the Royal Borough of Kensington and Chelsea.
- The chair of the LSCB has been in post since April 2012.
- The LSCB is shared with the City of Westminster and the Royal Borough of Kensington and Chelsea.

Children living in this area

- Approximately 33,777 children and young people under the age of 18 years live in Hammersmith and Fulham. This is 19% of the total population in the area.
- Approximately 29.7% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
 - in primary schools is 24% (the national average is 16%)
 - in secondary schools is 22% (the national average is 14%).
- Children and young people from minority ethnic groups account for 46% of all children living in the area, compared with 21.5% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Black or Black British and Mixed.
- The proportion of children and young people who speak English as an additional language:
 - in primary schools is 49% (the national average is 19%).
 - in secondary schools is 43% (the national average is 15%).

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.

Child protection in this area

- At 31 March 2015, 1,559 children had been identified through assessment as being formally in need of a specialist children's service. This is a slight increase from 1,459 at 31 March 2014.
- At 31 March 2015, 172 children and young people were the subject of a child protection plan. This is an increase from 161 at 31 March 2014.
- At 31 March 2015, four children lived in a privately arranged fostering placement. This is no change from four at 31 March 2014.
- Since the last inspection, two serious incident notifications have been submitted to Ofsted and three serious case reviews have been completed or are ongoing (regarding incidents which had taken place in Hammersmith and Fulham or involving resident children) at the time of the inspection.

Children looked after in this area

- At 31 March 2015, 185 children were being looked after by the local authority (a rate of 56.9 per 10,000 children). This is a decrease from 200 (62 per 10,000 children) at 31 March 2014. Of this number:
 - 142 (77%) live outside the local authority area
 - 13 live in residential children's homes, all of whom live outside the local authority area
 - four live in residential special schools³, all of whom live outside the local authority area
 - 138 live with foster families. Of these, 78.3% live outside the local authority area
 - one lives with parents, within the local authority area
 - 22 children are unaccompanied asylum-seeking children.
- In the last 12 months:
 - there have been 12 adoptions
 - eight children became the subject of special guardianship orders
 - 136 children ceased to be looked after, of whom five (3.75%) subsequently returned to be looked after
 - 18 children and young people ceased to be looked after and moved on to independent living.
- Eleven children and young people ceased to be looked after and are now living in houses of multiple occupation.

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

Recommendations:

1. Collate information drawn from return home interviews of children who go missing from home, to identify patterns and trends and assist disruption activity.
2. Ensure that children who are subject to the child protection process have access to a suitable independent advocate if they want one, to help them make their views known and understood, and to inform decisions about their lives.
3. Review out-of-hours arrangements to ensure that children and young people are offered a standard of practice consistent with daytime services.
4. Ensure that assessments and care plans for children looked after are updated following significant events.
5. Increase the range and number of apprenticeship opportunities for care leavers to reduce further the proportion who are not engaged in education, employment or training.
6. Improve the quality of the minority of pathway plans that are not yet good, so that outcomes are improved and the results of actions can be assessed more effectively.

Summary for children and young people

- Services for children and young people are good. Managers and staff in Hammersmith and Fulham want the best for all children and young people. When children and young people are unsafe, staff work well to protect them. The local authority is working hard to improve the experiences of children in their care. Children and young people told inspectors that they are very happy with the help they receive and they know that their workers want them to do their very best.
- There is a wide range of early help services that help families. This includes the excellent support provided by teams of different workers who work together to decide on the best way to meet a child or young person's needs. Workers listen to families and children, know them well and make sure that services meet the different needs of children.
- Children who are in the care of the local authority live in good-quality homes that meet their needs. These are found as quickly as possible so that they can stay in the same school and keep in contact with friends and family. Wherever possible, children from the same family live together.
- Children and young people have lots of opportunities to have their say about the service they receive, to help make services even better. Their views are listened to and they are involved in decisions about services. However, not enough children are using the independent advocacy service to help them get their views across at important meetings.
- The Children in Care Council now has more influence on decisions about services for children looked after, including the development of an 'app' (MOMO) to help young people to give their views, for example about new arrangements for accommodation.
- Children and young people who are looked after have really good support to stay healthy. The authority makes sure that they are in good schools so they make good progress. They do better at school than many children in the care of other local authorities. When they reach 16 years old, they get good advice and help to move on to the next step, but too few young people become apprentices. A high proportion of young people are in education, employment or training, and those who wish to go to university receive good help.
- Young people who are in Hammersmith and Fulham's care speak well of the very good support they get from skilled workers, who are very good at helping them to become independent adults. When they leave care, they are helped to move into homes where they feel safe, with the support they need.

The experiences and progress of children who need help and protection	Good
<p>Summary</p> <p>Children, young people and families benefit from a broad range of good-quality, well-coordinated services, at all levels of need. Children and young people are able to access early help support through the network of children’s centres and the early help service. All services are of good quality and are regarded positively by parents. Thresholds of concern are well understood and inform ‘step up’ and ‘step down’ decisions that are appropriate and proportionate. Management oversight is a clear strength, with social workers receiving regular, reflective supervision, providing clear direction and a shared ownership of risk from frontline staff to senior management.</p> <p>Children and young people referred to children’s social care receive a good service. This includes a timely response to referrals and the undertaking of comprehensive assessments, which routinely capture the views of children and young people. However, children do not have routine access to an independent advocate to support them through the child protection process. Multi-agency child protection enquiries are effective for those identified as potentially being at risk of significant harm.</p> <p>Planning to improve outcomes and reduce risk for children and young people is robust. Regular reviews ensure that progress is measured and risk is reduced for most children and young people. Sustained investment ensures that caseloads for social workers are manageable. This enables social workers and other practitioners to undertake direct and purposeful work with children, young people and their families.</p> <p>The ‘focus on practice’ initiative has been demonstrably effective in skilling the workforce to consider risk and resilience in order to achieve positive change for families. There is extensive provision of highly effective and innovative services, including the clinical and family assist teams, which utilise research-evaluated models of services to engage service users and achieve improvements in their lives.</p> <p>There is a robust and well-coordinated response to children at risk of experiencing child sexual exploitation, informed by the effective sharing of information and intelligence between all key agencies. Most children who have been missing from home are provided with the opportunity to discuss with their social workers their reasons for going missing on their return. However, the information from these missing episodes is not systematically cross-referenced to identify emerging issues for individual children, or to capture wider issues and trends within the borough.</p>	

Inspection findings

7. Good-quality early help is readily accessible to families in need of support across Hammersmith and Fulham. For families with children under five years old, this is usually through support from the borough's children's centres. For older children, the majority of referrals are received from schools into the local authority early help services. The borough's 'team around' approach ensures effective multi-agency work at a number of levels involving schools, children's centres and families. Interventions are well supported through the engagement of an appropriate range of professionals.
8. Having named contacts within all universal services ensures that early help referrals are appropriately directed into the service. The vast majority of referrals are assessed within a week, and the average length of case involvement is seven months. Early help services are effective in keeping families out of social work statutory services, and only 4% of cases escalated in the year prior to inspection. Progress for families is well evaluated through the use of 'family star', a recognised scale to provide evidence of parenting progress.
9. Local authority early help teams include a good range of appropriate professionals and, since the introduction of qualified social workers, escalations to child in need and child protection services have reduced significantly, as risk is managed well within the service. Teams have good access to a wide range of appropriate professionals and work well with the early years team and settings, especially to increase the number of vulnerable two-year-olds accessing free early years places and to improve transition to school. Communication and information sharing between partners working with families at all levels of early help are good.
10. The local authority early help services complete detailed assessments using the common assessment framework. Most contain focused, outcome-based action plans, although some lack clear, time-limited actions. For this reason, progress against intended outcomes for the family is not always clear. The findings of monthly case audits by managers are used effectively to identify concerns around practice and are shared with team managers, who use the information in staff supervisions to improve service provision. The majority of early help staff have either completed or are undertaking 'focus on practice' systemic training, and this is demonstrating improvements in their use of reflective practice. Thresholds are well understood by the vast majority of services and early help staff, with appropriate escalation or step-down where necessary.
11. When cases are open to children's social care, children and young people are seen, and seen alone, by social workers who know the children and young people well. Sustained investment in the service enables workers to have caseloads that are manageable. This ensures that direct work with children and

young people is well established in practice and creative methods are used to gather the wishes and feelings of children. Children and young people receive regular visits from workers, and the visits are recorded well in most case records. An understanding of their circumstances and history is enhanced by the routine use of chronologies and genograms. The local borough's offer for families with disabled children is well developed and ensures that a wide range of services is provided to meet need. This includes a direct link with a child protection adviser for the purpose of consultation and advice.

12. The manner in which new referrals to children's social care are made is robust overall, with partner agency referrals being appropriate and timely. All contacts are considered at the borough 'front door', leading to an initial risk analysis on a blue, red, amber, green (BRAG) basis. For those considered red or amber, the contacts are accepted as referrals and appropriate and timely statutory safeguarding practice occurs. For those rated green or blue, or where there is insufficient information, contacts are sent to the multi-agency safeguarding hub (MASH) to gather agency information to inform decision-making.
13. Although the MASH is highly effective in gathering and sharing information, the information gathering process can build in delay for a small number of children and young people. This may translate into further delays in the undertaking of assessments. When this concern was shared by inspectors with senior managers, practice was immediately changed to ensure that assessments now commence in a timely manner. Within all casework, there is a clear understanding of the need to work alongside parents and to gain consent to undertake further enquiries, where appropriate.
14. Threshold application and management decision-making are robust, and appropriately address risk and need. Records demonstrate a clear rationale for the decisions made in the large majority of cases. Decision-making and case direction records are evident on case files following formal meetings, such as supervision. Social workers report that they feel very well supported by managers at all levels, who are knowledgeable and available to them for advice and consultation. Social workers and their colleagues displayed confidence in their work and were clearly proud to work in the borough.
15. Team managers and the police hold timely strategy discussions. Most initial strategy discussions do not routinely include other professionals. While this did not adversely affect the outcomes in cases tracked or sampled, this practice does not support the sharing of agency information to fully inform decision-making. Subsequent strategy meetings do, more routinely, include information from other agencies.
16. In cases where children are considered to be at risk of significant harm, including harm from neglect, child protection enquiries are conducted in a timely way. Decisions to progress to formal enquiries are proportionate, and children are not made subject to formal child protection investigations unnecessarily. The Public Law Outline is used effectively to ensure that parents

understand professional concerns and what needs to improve for their children to be safe from harm. The widespread use of family group conferences increases the likelihood of child- and family-centred solutions. Where necessary, care proceedings are initiated to safeguard children and young people. This work is supported by good-quality legal advice.

17. Multi-agency meetings to review children in need and child protection conferences are generally well attended by all relevant professionals and, when unable to attend, professionals submit a report to the meeting. The use of research-evaluated models of practice has had a positive impact in ensuring that there is a proportionate response to risk and, for parents, a greater understanding of what needs to change. Children and young people are too infrequently supported to attend and participate within their meetings. Senior managers acknowledge that this is an aspect of the service that requires development (Recommendation).
18. Chairs of child protection conferences provide consultation to social workers and a good level of challenge where child protection planning is not driving change, to ensure that alternative actions are progressed. Although they routinely gather information via post-conference individual monitoring reports, these could be better aggregated in order to identify and improve practice issues regarding whether conferences are quorate, advocacy for children at conferences or the timeliness of the sharing of conference reports with parents and carers. Social work reports are of good quality, but parents and carers do not always receive reports in time to enable them to prepare and participate fully in conferences.
19. Families that are subject to child in need and child protection plans benefit from a comprehensive range of services. Many are highly innovative, such as the 'action for change' programme that is working with positive impact to break the cycle of mothers having children repeatedly removed from their care. Similarly, the family assist team provides a highly effective service to support children, young people and their families on the cusp of care. The team also works with other young people with complex needs and there is evidence of both tenacity and compassion in improving outcomes, while managing complex risks. The flexibility of the team to work with young people beyond 18 years old is a welcome development.
20. The 'focus on practice' initiative is having a demonstrably positive impact on improving outcomes for children, young people and their families. Following intensive accredited training, social workers and managers are employing a range of models of practice, such as systemic thinking and strengthening families to achieve sustained improvements in the lives of children and young people. The clinical team, through the work of experienced psychologists and family therapists, adds a further, highly regarded, dual service. The team has a consultancy role for colleagues, while also undertaking direct work in complex cases.

21. Specialist workers in relation to domestic abuse, child sexual exploitation and young people's mental health also work effectively in improving outcomes for children and young people. All undertake direct work to meet diverse and complex needs. In addition, they provide consultation and advice to colleagues and, on occasion, co-work on complex cases. Such work is used well to inform risk assessments and plans, with several good examples of risks being reduced as a result.
22. Hammersmith and Fulham is subject to Department of Education exemption with regard to the timeliness of the completion of assessments within 'Working Together 2015' guidance. The large majority of assessments and plans are of good quality. Of the 445 completed assessments in the six months prior to this inspection, 87% (386) were completed within 45 working days. For the majority of assessments outside this timescale, there was purposeful delay and no negative impact. Assessments consider current as well as historical concerns, consider the effects on the child or young person, and routinely evaluate risk and protective factors. Assessments include consideration of fathers, even when they are absent. When needs are identified, children, young people and their families do not need to wait for support until the assessment is completed. Managers regularly review child in need plans to track progress and the child protection advisers chair meetings where casework is complex. Overall, assessments provide a sound basis for planning and intervention. However, they do not demonstrate that they always fully consider children's identity needs, which means that plans cannot always fully address these.
23. Most social workers receive effective and timely supervision. The availability of specialist workers to provide consultation, advice and targeted interventions is a considerable strength within the borough. Social workers benefit from formal and informal opportunities to reflect on their practice and consider alternative approaches in their work and the impact of the interventions on themselves. Reflective practice groups provide further opportunities for staff support.
24. In January 2016, over 50% of children subject to child protection plans were living in households where domestic abuse was present. For children living in households where there is a high risk of domestic violence, multi-agency risk assessment conferences (MARACs) are effective, with good representation and input from partner agencies. The programme provides information to schools in the borough within 24 hours, when pupils have been exposed to domestic violence, so that support can be arranged if needed. Substance misuse services provide effective support for young people and adults.
25. Significant progress has been made to tackle child sexual exploitation, with effective tri-borough multi-agency arrangements ensuring that information is shared swiftly and that children at risk of child sexual exploitation are identified, monitored by senior leaders and robustly assessed. The work of the dedicated sexual exploitation workers linked to gangs contributes effectively to the extensive tri-borough response. Awareness-raising activities have taken place with children in schools and colleges.

26. Within the borough, in cases where child sexual exploitation is known or suspected, there is good evidence that the work of the child sexual exploitation lead officer is effective. The role serves to provide consultation to colleagues, to raise awareness of the issue and to steer actions and decision-making for identified vulnerable young people. Information sharing at multi-agency forums – including the multi-agency sexual exploitation meetings, the borough child sexual exploitation panels and the Deter and mapping bi-monthly meetings – gives a focus on both victims and perpetrators. There is comprehensive consideration of need, including sexual health and protection.
27. Use of the child sexual exploitation tool is evident in casework. Ongoing work to develop a version that contains evaluative data is intended to enhance its effectiveness further. In several cases considered by inspectors, there was very good work in engaging with victims of child sexual exploitation, with broad and considered multi-agency activities, including out-of-borough exchanges to protect the most vulnerable. Important contributions from the voluntary sector agencies, including a specialist Barnardo's project, help to expand the breadth of support services.
28. The missing children's coordinator (MCC) systematically collects data, tracks cases and delivers training and consultation in relation to missing children and young people. Information about children and young people missing is shared weekly with heads of service, and persistent absconders are monitored at the care panel. Risks are monitored effectively and are escalated. Incidents of children and young people who frequently go missing result in strategy meetings being held.
29. The missing children's coordinator has provided helpful, accessible tools for practitioners, including 'return interview guidance – areas to cover' and a 'tri-borough quick guide for missing children procedures'. These provide clear, short summaries on what social workers should do and include appropriate prompts to understand 'push and pull' factors. There is good evidence of this facilitating social workers' understanding and actions. The tri-borough strategic panel has identified that they need to do more to aggregate patterns and trends (Recommendation).
30. Local authority staff ensure that an increasing proportion of children and young people attend schools and colleges. They have clear strategies for reducing absence and increasing attendance, and respond quickly when children go missing from education. Staff are particularly proud of the 'team around' approach in partnership with other agencies and schools, to support children and young people who get into difficulties at school. The team managing exclusions in the borough is highly motivated, and fully understands the processes for absences and children missing education, which they implement effectively.
31. Staff have investigated and resolved 45 episodes of children missing education that have occurred during this academic year. Staff fully understand the

overseeing role of the attendance, child employment and elective home education and children missing team (ACE), which helps to identify and track children and young people who go missing in the tri-borough area.

32. Absences and fixed-term exclusions of children in need are reducing. School-aged unauthorised and authorised absence overall decreased from 10.8% in 2012/13 to 7.3% in 2013/14. In addition, there was a reduction in persistent absences from 13.8% in 2012/13 to 7.5% in 2013/14, lower than similar authorities at 13.2%, and England at 13.8%.
33. Reasons for elective home education (EHE) are carefully scrutinised and action is taken to safeguard children if necessary. The number of electively home-educated children was 65 in the autumn term 2015. Eight children are currently in alternative provision.
34. Assessments for 16- and 17-year-old homeless young people cover a wide range of issues, including health, offending and substance misuse. There is a comprehensive joint protocol for the assessment and provision of help for homeless 16- and 17-year-olds, jointly operated with the housing department. Close working between social care and housing is enhanced through two jointly funded posts. For this reason, those young people who cannot be supported to return safely to home are placed in suitable alternative accommodation.
35. The tri-borough emergency duty team responds to crises and emergencies out of hours and ensures that safe arrangements are in place and action is taken to protect children and young people when required. The team does not follow formal statutory child protection procedures and processes. This means that while children may be safe, their situation remains unassessed and families are left waiting until day-time services initiate child protection processes. In addition, there is evidence of children and young people being placed in care without being seen by a social worker. Carers were not provided with written information to care for them most effectively (Recommendation).
36. The tri-borough arrangements for the management of allegations against members of the children's workforce have been in place since October 2014. They are suitably robust and effective. Each borough has retained responsibility for progressing and dealing with referrals via the child protection advisers who chair strategy meetings and ensure that cases are tracked and outcomes are recorded. Cases sampled across each borough demonstrated that appropriate action was taken and that outcomes were proportionate to the allegations addressed. The designated officer retains performance data within each of the boroughs, and has regular oversight. The designated officer role encompasses the promotion of safe working environments and safe recruitment practices not just allegation management, to help address safe working practices.
37. Social workers and managers are alert to the potential for radicalisation. Inspectors saw appropriate actions and consideration through assessment and strategy meetings. Multi-agency 'Channel' meetings are convened where

appropriate, to consider and share information to inform risk assessment, planning and preventative actions. Proactive work by the police, including the use of legal orders, has effectively addressed immediate concerns and reduced the risks of radicalisation and forced marriage, by ensuring that families remain in this country and that their activities are appropriately monitored.

38. Following a wide range of training and awareness-raising activity in relation to female genital mutilation, referrals to children's social care are increasing. A tri-borough female genital mutilation project has been effective in extending the existing work within female genital mutilation maternity clinics, through the creation of a specialist social work post. This specialist undertakes assessments jointly with health colleagues, seeking to develop a trusting relationship with service users to include a safeguarding assessment of female children, including those yet to be born. The addition of a male worker within the team has been successful in engaging fathers and husbands, particularly those of Somalian descent, in discussion and reflection on this practice.
39. Strategic oversight of private fostering demonstrates that it is well coordinated, with a knowledgeable, dedicated worker who undertakes all assessments and offers continuous support to children and families in the four current arrangements. Effective and innovative awareness-raising takes place on a regular basis, including targeted work with general practitioner forums, language schools, independent schools and UK Visas and Immigration. This has led to an increase in enquiries and referrals in relation to private fostering arrangements.
40. Issues in relation to diversity are usually addressed in assessments and planning for children and young people. In cases where children are from minority backgrounds, issues of culture are more readily identified and explored to inform assessments and planning. Further work is required to ensure that issues of identity and sense of self are explored sufficiently for all White British children, for example, those growing up in areas of high deprivation or with complex backgrounds, and with life experiences such as gang culture.

<p>The experiences and progress of children looked after and achieving permanence</p>	<p>Good</p>
<p>Summary</p> <p>Decisions about whether children need to become looked after are timely and appropriate. A wide range of multi-agency edge of care support is in place, which enables children to remain safely at home, or return home from care where at all possible. Practice before and after care proceedings is effective and well managed. Permanence is given high priority across the tri-borough partnership and leads to the majority of children and young people being placed in a timely fashion in permanent families.</p> <p>Social workers know children well, regularly visit them and give sensitive and thoughtful consideration to their needs. As a result, children and young people achieve positive outcomes. A minority of assessments and care plans are not always updated or thorough and this is an area for development. Arrangements to track children who go missing from care are robust and are appropriately in place. Although there is accurate and timely recording of return home interviews on children’s files, systems to establish and monitor high-risk young people and collate patterns and trends are areas for development.</p> <p>Children looked after are very well supported in all areas of their education by the virtual school. The fostering service offers good-quality placements to children and young people but requires more foster carers in order to improve choice and availability. The tri-borough partnership is implementing a range of improvements to increase placement choice.</p> <p>The independent reviewing service regularly reviews care plans. Independent reviewing officers know children and young people well, and provide positive support outside of the reviewing process. There is a culture of informal and formal challenges to care plans. The Children in Care Council is effective and well established.</p> <p>The quality of adoption practice is outstanding. Adoption is considered for all children looked after, including those with complex needs. Higher than average numbers from minority ethnic groups and children over five are adopted. A particular strength of the authority is the care that goes into the matching process.</p> <p>The care leavers’ service has rapidly improved over the last year and is now delivering good-quality services to young people. Areas for development are in the quality of pathway planning and support to young people who are not in education, employment or training.</p>	

Inspection findings

41. At the time of the inspection, Hammersmith and Fulham looked after 189 children. The rate of children becoming looked after, at 55 per 10,000 in 2014–2015, is significantly lower than in similar authorities and England (70 and 60 respectively). There has been a slow and steady decrease in the number of children looked after since 2012–13. This is the result of effectively investing in a wide range of early help and flexible edge of care services, which support children and young people to continue to live with their families, or to be successfully returned home from care.
42. As a result of the tri-borough arrangements, positive services and developments for children looked after are centralised and amalgamated. This enables economies of scale, improvements in consistency and quality of practice, flexibility in the use of resources and an enhanced profile across the London region. Examples of strong practice include a tri-borough connected persons' team, the independent review service and the commissioning of placements for children looked after.
43. The majority of children and young people achieve improved outcomes as a result of becoming looked after. Their needs are met, they thrive in a variety of placements and are kept safe. Decisions about whether children need to become looked after are timely and appropriate, and safeguarding risks are responded to well. A range of multi-agency partners provides extensive support and early help services so that children and young people can live with their families where at all possible. Almost all children and young people receive good help to return home, and their views and wishes are considered. Parents are appropriately engaged and supported. High levels of social work visits and the involvement of a range of multi-agency partners enhance planning.
44. The tri-borough partnership's arrangement enables consistent management oversight where legal proceedings are required for children. The tri-borough care proceedings manager reports to a strategic tri-borough management team and other key professionals, to ensure timely placements for children, through very effective and proactive monitoring of the Public Law Outline. Tri-borough performance is variable, with average median timeliness of care proceedings at 29 weeks in 2014–15, which is better than the England average of 30 weeks, but increasing to 32 weeks in the third quarter of 2015–16. Further improvement is anticipated as long-standing cases conclude. The University of East Anglia provides further independent scrutiny and analysis. Delays are extensively tracked and are mostly attributed to long-standing, complex and international casework.
45. Tighter practice is acknowledged by the judiciary, the Child and Family Court Advisory and Support Service (Cafcass) and by managers in the tri-borough partnership. Cafcass reported that the tri-borough partnership is 'leading the way' and a family proceedings judge reported that the tri-borough partnership's arrangements 'stand out as leading good practice' across London. Average

timeliness of proceedings is improving in Hammersmith and Fulham from 35 weeks in 2013–14 to 32 weeks in the third quarter of 2015–16.

46. Parallel planning is rigorously and systematically applied. Family group conferences are used at an early stage to inform care planning and to identify members of the extended family. Viability assessments are clear and of a good quality, with appropriate management sign-off.
47. Strategically, across the tri-borough partnership, achieving permanence is given the highest importance, to ensure that all aspects of permanence are developed, embedded and improved. A permanence board and a specific permanence worker oversee a broad range of initiatives, for example clear permanence guidance for staff, a sub-clause in independent fostering agency (IFA) contracts regarding staying put, and assistance with children's permanence reports for social workers.
48. A tri-borough permanence coordinator very effectively tracks early permanence planning, and for some children this commences pre-birth. Permanence planning meetings, overseen by managers, happen regularly for children and young people, so that they are matched in a timely way to the most appropriate placements.
49. Children and young people are listened to by social workers who know them well, and are appropriately involved and engaged with a range of professionals. Social workers see children and young people alone, offer sensitive support and care, and are in regular communication, visiting often beyond statutory requirements. Case records are up to date, comprehensive and accurately reflect the situation of the young person.
50. A pledge for children looked after is in place and reviewed annually. This links appropriately to themes arising at the corporate parenting board and within the children looked after strategy. Children and young people who met with inspectors during the inspection were aware of their entitlements, and relevant issues such as pocket money or clothing allowances, as these are highlighted in regular newsletters to them. The children's rights service provided advocacy for 44 children and young people during 2015 for support around placement issues, attending meetings and helping with complaints. A tri-borough complaints service works hard to resolve dissatisfaction for children looked after at an early stage, which means formal complaints are relatively low. A well-established independent visitor scheme is in place, with eight young people linked and 12 independent visitors in place.
51. The majority of children and young people's needs were assessed appropriately, using a wide range of assessments, and incorporating the views of families and other professionals to enhance outcomes. Not all assessments seen by inspectors were updated or were properly completed as a child and family assessment. This means that for some children, where there had been

significant change or emerging new risks and needs, this had not been thoroughly assessed or updated (Recommendation).

52. The majority of plans for children demonstrated sensitive and thoughtful work, which was effective and measurable. Some plans seen were not updated, or had no measurable outcomes, and some lacked analysis. This means that children and young people and their families cannot fully check that actions are completed and that continual progress is being made in a timely manner. This is an area of casework that requires further development (Recommendation).
53. The performance of the tri-borough independent reviewing service is very high. In 2014–2015, the vast majority (96%) of children had regular reviews of their care plans and 97% of young people participated in their reviews. There is a culture across the tri-borough partnership of issues being resolved either at a very early stage, or via informal and formal challenges, which leads to positive changes to care plans for children and young people.
54. This highly positive practice is supported by manageable caseloads, effective tri-borough training, including action learning sets six times a year, and good links with managers and staff to keep abreast of developments. Independent reviewing officers are able to get to know children and young people well and to advocate for them, meeting them midway between statutory reviews and providing additional reviews for more complex situations.
55. The vast majority of children live in stable placements with their brothers and sisters. Short-term placement stability has improved considerably, from 20% in 2013–14 to 9.2% in 2014–15, compared to the England average of 11% for 2013–14. This has been achieved by reconfiguring the service for children looked after in July 2015, to include a focus on better matching, planning and analysis of children's needs. The diversity of children's needs is fully encompassed and carefully matched to ensure that the best placement is made available to them, including appropriate attention to their cultural, ethnic and religious needs. This means that most children and young people achieve good outcomes, they settle and achieve, return to school, go missing on fewer occasions, and build positive relationships with foster carers or other carers.
56. Local authority staff, foster carers and the virtual school effectively promote a wide range of children's interests. Delegated authority is in place for foster carers to take some day-to-day decisions so that children and young people can participate in the activities they enjoy.
57. Missing reports, received from the police for individual children and young people, are well coordinated and passed efficiently to appropriate staff. An increased recent focus on the need to improve practice in return home interviews for children who go missing from care has led to a more individual and flexible approach, by identifying the best person to undertake these. Additional training and briefing to staff has also been delivered. This is starting to have an impact on practice, with the quality of interviews improving. The

accurate and timely recording of return home interviews on children's files and establishing systems to monitor high-risk young people and collate patterns and trends continue to be areas for development (Recommendation).

58. Appropriate and sensitive contact arrangements are in place for children. This is well managed by a designated contact service, with permanent staff who provide continuity and familiarity.
59. The youth offending service and a commissioned drugs and alcohol worker are co-located with the children looked after teams and offer direct work and appropriate support and advice to young people who offend or who are misusing drugs and alcohol.
60. The designated looked after children nurses offer a highly sensitive, personalised and consistent service to children and young people, including those who are placed out of the borough. For example, in 2015–16 to date, only seven young people will have been seen by an external professional other than the looked after children nurses. Care and attention are taken to keep in touch with young people and to get to know them informally. As a result, the performance of review health assessments was high at 93% in 2013–14 and is anticipated to be 96% for 2015–16. This means that children and young people are made aware of their health needs and immunisations and are well prepared to manage their own health needs as they mature.
61. A child and adolescent mental health service offers bespoke therapeutic support to children and young people looked after, including those placed out of the borough. The 'focus on practice' training and consultations also enable a range of professionals to work therapeutically and systemically, to support children and young people within their placements.
62. Children looked after in the borough's care achieve well in their primary schools. The number of children looked after included in data at Key Stage 2 is small. However, for these children, progress is good and the proportion that attain the expected national levels is much improved and high. For example, 2014/15 London borough data indicate that seven out of eight achieved the expected national level in reading, writing and mathematics compared to half in 2012/13. Most make at least the expected progress in reading, writing and mathematics between Key Stages 1 and 2, and this has improved since 2012/13 when less than half made the expected progress.
63. The number of children looked after included in data at Key Stage 4 is also small. Nevertheless, attainment is improving. In 2014/15, London borough data indicate over a third (37%) of children looked after gained at least five GCSEs at grades A* to C, including English and mathematics, up from a fifth in 2012/13. The majority gained at least five GCSEs at grades A* to C, including English and mathematics. Most children (83%) looked after go to a good or better school in or out of the borough and no children looked after attend an

inadequate school. The proportion in a good or better school has been steadily rising over the last few years.

64. Managers and staff of the virtual school have good oversight of the learning of children looked after. They achieve this through a range of useful initiatives in schools in the borough, skilled advisory teachers and the close tracking of progress. The pursuit of good outcomes for children and young people looked after, by improving their progression and attainment, is a key focus for the virtual school. Monthly monitoring checks reinforce this aim and ensure that increasing numbers are attending and achieving. School leaders recognise and value the enthusiasm, visibility and expertise of virtual school staff in the borough.
65. In 2014/15, London borough data indicate an increase in the attendance rate of children looked after to 92%, three percentage points higher than the previous year. Absences from school are reducing, and there have been no permanent exclusions of children looked after for the last three years. Action in response to children who fail to attend school or go missing is effective. A very few children (eight) who find learning too difficult at school, due to complex barriers to learning or behavioural issues, are allocated appropriate alternative provision. Five children looked after post-16 are currently not engaged in education, employment or training. The virtual school is constantly looking for ways to improve provision and is focusing currently on further reducing fixed-term exclusions and persistent absences of children looked after.
66. The planning for children looked after is consistently good at different ages and in different settings. Personal education plans (PEPs) effectively capture the progress the child is making in their learning, their emotional needs and their transitions to different schools and key stages. In one case, where a young person had not achieved what they had expected, staff used the PEP well to establish a purposeful study programme. This met the young person's needs, and they are now achieving well in college. The processes for assessing and allocating pupil premium needs are thorough, and staff monitor pupil premium use well.
67. The virtual school staff have established good working relationships with headteachers. They have introduced good initiatives to help improve educational understanding of barriers to learning across the borough, such as the emotional trauma and attachment difficulties that children looked after can present. They facilitate useful enrichment and extra-curricular events to add value to learning in schools. These include a family-learning project with a national museum based in Kensington and a film project where children achieved a qualification and celebrated their work with carers at a local theatre in Hammersmith and Fulham.
68. The local authority has introduced a number of effective procedures and initiatives for raising awareness of safeguarding, promoting safe learning environments and taking action to keep young people safe. This includes

support to help children learn to use the internet safely, awareness of cyber-bullying and work with other agencies to prevent radicalisation.

69. Most children looked after in Years 12 and 13 participate and remain to complete their learning in further education. The proportion of children looked after in 2014/15 that progressed to study programmes, apprenticeships, or other learning post-16 is 85%. However, few of these are apprenticeships and it is insufficiently clear if any are on a study programme. While this is improving, managers are acutely aware that, in a few cases, staff have not always made sufficient links between personal education plans and pathway plans as children progress through Key Stages 4 and 5.
70. Children are appropriately matched within the fostering service. If this is not possible, a well-established and experienced placements team ensures careful planning and sensitive matching for children and young people. Children are placed appropriately with their brothers and sisters and have carefully arranged contact with their families. Every effort is made to ensure that children and young people living out of their home borough are not disadvantaged by being away from their school and local community.
71. A comprehensive tri-borough sufficiency strategy outlines a sophisticated understanding and approach to the placement needs of the whole children looked after population, and work is progressing to improve placement choice. Strong and effective relationships exist with independent providers, and the tri-borough partnership has been influential in commissioning improved placements for young people with specialist needs.
72. The tri-borough fostering service has more 'in house' placement choice as a result of being amalgamated, with wider flexibility to use staff, resources and carers. However, there are recognised gaps in placement choice for young people with challenging behaviour, brothers and sisters, children with disabilities and children requiring long-term fostering or permanence. There is a 16% net deficit in terms of foster carers retiring or as a result of offering permanent placements or staying put arrangements. To address this, an ambitious and proactive fostering recruitment programme to recruit 25 new carers commenced in October 2015.
73. Creative use is made of foster carers who have vacancies, for example accompanying children and young people to school and making contact where their existing carer is unable to do so, supporting children who return home to parents, and acting as a mentor for young people involved in drug and gang culture.
74. The recruitment and assessment of prospective foster carers are compliant with regulations. Social workers sensitively and thoroughly assess foster carers, focusing on strengths and areas for development. A well-organised and separate tri-borough connected persons team is in place to respond in a timely

and thorough way to all connected persons and special guardianship assessments.

75. Support and training offered to foster carers and connected persons are good and retention of foster carers is strong. Respite care in fostering is used in a child-focused way and only if really necessary to support placement stability. All carers spoke very highly about their supervising social workers. Annual reviews are regular, and are independently undertaken by dedicated fostering independent reviewing officers, ensuring that effective practice is in place.
76. Where children and young people are not immediately placed for permanence, a dedicated family-finding social worker is allocated to progress this. Evidence was seen of appropriate and careful matching of children to long-term carers or permanent carers, and every effort is made to find the appropriate cultural and ethnic match. Children and young people are helped to form strong attachments with their carers. Five life story books seen were of a good standard, and some were exceptional.
77. There is an effective Children in Care Council (CiCC) for older and younger children looked after, with a real focus on informing and influencing the decision-making and discussions at the corporate parenting board.
78. Care leavers reported that the CiCC is increasingly effective. Examples of impact in changing or developing services include the development of an 'app' to improve participation for young people (MOMO), and being involved in consultation relating to the new semi-independent accommodation framework.

The graded judgement for adoption performance is that it is outstanding

79. Local authority staff have a very strong commitment to achieving permanence through adoption for all children assessed as likely to benefit from being adopted. This includes older children, children with complex health needs and larger family groups. Children being placed for adoption receive high-quality social work support and are well prepared. Placement matching is rigorous and tenacious, with high priority given to securing the best possible match. One consequence of this diligence is that no placements have broken down in the last two years.
80. The validated adoption scorecard performance for 2011–14 shows that the average time between a child entering care and moving in with their adoptive family was significantly above the national average, as was the average time between a local authority receiving court authority to place a child and the local authority deciding on a match to an adoptive family.
81. However, this performance is explained by some long-standing cases where children have been adopted by their foster carers after living with them for several years, and by the authority's determination to find the right match for

harder-to-place children. This is supported by the fact that the authority's performance in placing older children and children from minority ethnic groups is good and better than in similar authorities. More recently, timescales overall have been reducing. Younger children are placed without delay and, in all other cases seen, delay was purposeful in terms of supporting a child's preparation and identifying the right placement.

82. Twelve adoptions took place in 2014–15. Three children took longer than 16 months to be placed with their permanent families for a variety of complex reasons, including appeal against the court judgement. In all cases, the local authority maintained the care plan that was in the best interests of children and, in all cases, the outcomes for the children involved were positive.
83. The fostering and adoption service is provided on a tri-borough basis and is well led by experienced leaders for whom this work is a specialism. It is their clear aim to achieve the best outcome they can for children. In recent and current cases of children being placed for adoption, there are examples where the adoption process has exceeded the usual timescales, but in all of these the reasons for this were centred on the needs of the child.
84. Assessments of children and their families are recorded in appropriate detail in their child permanence reports, with their needs clearly identified and analysed. Several examples were seen of children who were matched with agency adopters who closely matched children's complex ethnic and cultural identities, even though the local authority had a surplus of adopters who might have met the child's needs, albeit to a lesser extent. Children are well prepared for adoption. All receive life story work that is of a consistently good quality. Inspectors saw one exceptionally good example where the social worker had gathered photos and information from abroad to record the family's history for a child and had had the book professionally bound.
85. Dual approval for concurrency and foster-to-adopt is considered and discussed with prospective adopters across stage one and two assessments. A number of adopters spoken to by inspectors had fast-track assessments in order to undertake foster-to-adopt placements where the prospective adopters exactly matched the needs of very young babies. Several second-time adopters had their assessments fast-tracked to facilitate younger children being placed with their already-adopted brothers and sisters. All prospective and new adopters are offered an experienced mentor to support them and help them to find their way around the systems, as well as to cope with introductions and help to settle newly placed children. Adopters spoken to really appreciated their support. Most adopters waiting to be linked or matched were open to considering a wide range of children. Where prospective adopters were not matched within three months, they were supported to join the national register and their details were made available to other local authorities.
86. A total of 16 adopter assessments have been completed to date during 2015–16 for the tri-borough partnership, against a target of 25. Of these, none met

the timescales, although in nearly all cases, delays were beyond the control of the local authority.

87. The recruitment, assessment and training of adopters are completed to required safeguarding standards. Adopters spoken to valued the input they had received and felt assessment timescales were challenging, but appropriate. The tri-borough partnership has a surplus of approved adopters and 11 adopter households have been enabled to provide good-quality homes for children outside the borough in the last year.
88. The agency decision maker for Hammersmith and Fulham has substantial adoption experience and is well informed on all issues affecting the timeliness of assessments and placements. The agency decision maker meets with the independent chairs quarterly and has carried out annual appraisals of both. Feedback on practice from the panels is used as a basis for service improvement.
89. Adopters seen were all aware of their entitlement to support for their child. They valued the confirmation of school-place priority and pupil premium and, particularly, support with the medical and therapeutic needs of their children. In all cases seen by inspectors where placement orders had been granted, there was evidence of birth parents being offered referral to support services and mothers were offered referrals to commissioned services to avoid repeat pregnancies where proceedings were likely to result. Most adopters are able to access good-quality support and some adopted children receive excellent therapeutic support for extended periods of time, in accordance with their assessed needs.

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

90. The quality of services for most care leavers has been good, and is consistently good for those leaving care now. Staff provide well-considered advice and guidance to ensure that plans for young people moving towards independence enable them to make a secure transition from care. They provide close support to ensure that they are safe in their housing or sure of the next steps they need to take in their learning, and they provide good support when care leavers get into difficulties in their everyday lives. They are in touch with all but three care leavers. Over three quarters of those leaving care now stay with their carers until aged 18.
91. Staff development to improve the service is ongoing and purposeful, such as training to improve outcomes for young people and children through 'focus on practice'. This training helps to identify, among other things, systemic reasons why successive generations fail educationally. For example, some care leavers are hampered by inter-generational apathy to learning. Staff are putting the

training to good use to make the right decisions, to break down barriers that perpetuate a cycle of poor outcomes, by encouraging or recognising where a young person could improve their life chances in progressing to higher levels or by engaging in learning.

92. The quality of pathway planning and reviews for care leavers has improved markedly over the last few years, through improving the performance in capturing and recording information in plans and reviews, and in the recruitment of staff with a good range of skills and experience. Two thirds of pathway plans are good, and this represents a rapid and sustained improvement over the last two years. The best plans provide a detailed picture of how the young person is making progress to be able to live independently of support. Actions show good insight into the young person, are decisive, and are in their best interests. Information in plans shows careful monitoring of the care leavers' entitlements and contains good actions to improve life skills, such as financial management. Plans include the young person's voice effectively. The virtual school staff and social workers consider personal education plans carefully and more frequently, and use them increasingly effectively for guiding young people towards moving to independence as part of pathway planning.
93. A small number of pathway plans are insufficiently clear regarding plans for the future. Targets are not clear enough and target dates are not tightly linked to actions. Managers are fully aware of this and have good oversight of where improvement is necessary, with plans in place to address this area of improvement (Recommendation).
94. Specialist designated nurses for children looked after skilfully assess the health needs of care leavers prior to their 18th birthday. A final-review health assessment provides comprehensive information for all young people, including those placed out of the borough. The local authority is developing a new 'moving on healthcare plan' in conjunction with young people to improve the quality of the information further. Nurses give young people all of their key health information, including the dates of all of their immunisations, and discuss carefully with them what they think they might need in the future.
95. Nurses provide good, ongoing, informal support to care leavers. The local authority is seeking to improve the arrangements further by negotiating a formal health offer to care leavers over the age of 18 with the clinical commissioning groups (CCGs). Transitions to adult mental health services, including for young people who have disabilities, are progressed effectively locally, or through the complex needs panel. A designated nurse attends where appropriate and is effective in brokering services for young people. Pathway plans contain sufficient information on care leavers' health. The best plans contain purposeful recommendations and timely targets for the young people to access health services.
96. Care leavers comment that the care leaving service has improved and they have greater faith and trust in the skills and empathy of their social workers,

and their abilities to help them. A few who have been care leavers for a while say that this was not the case a few years ago. Those who have participated in the CiCC for young people feel that it has a strong voice in improving the quality of the care-leaving service. For example, one care leaver feels care leavers' views made a difference in changing a poor service provider for accommodation to one that now provides a much better service.

97. The suitability of accommodation and the swiftness of allocation are much improved. The proportion of care leavers in suitable accommodation is 94%, according to local data, and this has increased from 82% in 2013–14. Staff work together effectively to make sure accommodation is safe and in good condition. Staff take good decisions to make sure that the type of accommodation is in the best interests of the care leaver. Care leavers say they feel safe in their accommodation. Where emergency accommodation is used, it is rare and for good reason. Where young people feel unable to take the next step into their own accommodation, they stay with their foster carers until they are ready.
98. The local authority is focusing on and succeeding in increasing the proportion of care leavers who progress into higher education, employment and training. The proportion of care leavers in education, employment and training has been steadily increasing over the last few years and, although still too low, increased to 54% in 2014/15. Of these, London borough data indicate around 8% progress to higher education, 13% enter employment or training and 34% go into other learning. The proportion of care leavers not in education, employment and training has decreased over the last few years: local authority figures indicate 36% at the end of 2015.
99. In addition to the increasing proportion of care leavers going on to further learning and employment, the quality of the outcomes are better, as care leavers follow courses and employment that they plan with staff more thoughtfully to suit their prior attainment and needs. When they progress, care leavers are all going into a range of full-time vocational training, employment and higher education institutions. However, staff recognise the need to improve the options and progression pathways for care leavers. A recent staff appointment aims to increase, among other aspects of the role, the insufficient range of apprenticeship opportunities that are currently available (Recommendation).
100. Care leavers are fully aware of their entitlements, for example up to £2,000 for setting up home, or £5,000 support to go to university. The information that outlines entitlements for care leavers is clear online and in local authority information booklets. Care leavers are fully aware of the support they can get legally. The care-leaving service works effectively with other agencies to keep care leavers safe and to support them when they get into difficulties. The range of professionals on the one site enables good co-working and consultation to make sure that care leavers receive good advice, guidance and support.

Leadership, management and governance	Outstanding
<p>Hammersmith and Fulham’s arrangements for leadership, management and governance are outstanding. The borough benefits extensively from the economies of scale and quality of highly effective shared services afforded by its involvement in the tri-borough agreement with Westminster, and Kensington and Chelsea. This promotes solidly good social work practice, with some outstanding features. Progress has been sustained and improved since the last inspection in July 2011. The tri-borough partnership focus on continuous learning is particularly impressive.</p> <p>Elected members and most statutory partnership boards, including the LSCB, effectively deliver governance of services. These link regularly and directly to the tri-borough partnership’s Executive Director of Children’s Services (DCS) and other senior managers, who manage this complex arrangement extremely well to ensure that a ‘culture of compassion’ is evident and effective in all social work practice.</p> <p>Senior managers use the comprehensive tri-borough learning and improvement framework well to ensure that they have an accurate understanding of their service. Where weaknesses are identified, appropriate plans are put in place to improve services and outcomes for children. A restructure of the children looked after and care leavers service has led to tangible improvements in outcomes.</p> <p>Children and young people in the borough benefit from good-quality services. The highly effective ‘focus on practice’ project, implemented across the tri-borough partnership, enhances social work intervention by adopting a well thought-through and extremely well-resourced model of practice. Social workers spoke with enthusiasm about working in a child-focused and systemic manner to support families and to effect positive change. They are supported very well to achieve this, with manageable caseloads, regular supervision, access to expertise through consultations and child-centred management oversight. Effective, targeted, strategic workforce development has led to an increasingly stable workforce. Newly qualified social workers have an effective induction and training programme. Additional resources are provided to ensure that they are well supported.</p> <p>Performance management arrangements are good overall, enhanced by a programme of regular and rigorous auditing that includes innovative ‘practice weeks’, where senior managers audit a high number of cases and undertake an analysis of findings. Partnership working is strong, although the borough could do more to engage the health and well-being board in children’s and young people’s issues. Well-established and highly effective tri-borough commissioning arrangements deliver a wide range of high-quality services for children and families. As a result, social workers are able to identify services to meet the need of the families they work with to increase the chances of better outcomes.</p>	

Inspection findings

101. Leaders and managers in Hammersmith and Fulham have delivered significant improvements in services, all of which are now judged to be good, and, in the field of adoption, outstanding. The authority has clear plans and political and managerial commitment to continue on its journey to provide consistently high-quality services for children.
102. Strong tri-borough management arrangements are demonstrated by the well-managed 'focus on practice' initiative. Funded as part of the government's innovation programme, this project enhances social work intervention by adopting a well-considered and well-resourced model of practice. Innovative elements include a comprehensive and accredited training programme, and skills coaching from trained specialist practitioners. The model has been widely disseminated but understandably is at different stages of development across the three boroughs, and its impact was not evident in all the cases observed and tracked by inspectors in Hammersmith and Fulham. Social workers were, however, enthusiastic about the approach and its potential for improving practice with children and their families.
103. Senior managers across the tri-borough partnership communicate regularly and effectively. They operate within a culture of respectful challenge and they will, when necessary, hold each other to account. The senior management team, including the DCS, is highly interactive with frontline services and knows individual children and social workers very well. Robust lines of communication from frontline social workers to senior managers enable managers to know their services to children thoroughly and extensively.
104. A formal cycle of meetings between the DCS, the LSCB chair, senior leaders, such as the borough's chief executives and elected members, ensures that they are informed on matters for which they hold strategic responsibility. The lead member demonstrates passion and commitment and undertakes extensive activity to ensure a detailed knowledge of the service, which enables them to offer challenge and to influence service provision.
105. Other senior and political leaders express similar commitment to delivering high-quality services, assisted by a comprehensive suite of concise and consistent performance reports. This ensures that managers and leaders are knowledgeable and well-informed about their service's performance against key indicators, and this enables them to understand it well. There is, however, a lack of regular reports from the service in relation to performance management and quality assurance work to the relevant scrutiny committee. This means that these political leaders are not always able to identify or focus on key performance and quality issues for children's services. In some cases, issues of data accuracy, for example in recording the ethnicity of children referred to the service, have led to delay in their ability to undertake effective analysis.

106. A very comprehensive learning and improvement framework sets out clear expectations, and ensures that senior managers' thorough oversight is used to drive improvements in practice. The 'Learning and improvement framework quarterly report' is highly effective in collating findings from serious case reviews, user feedback (including young people, parents and carers), complaints and compliments, monthly audits and practice weeks. Rigorous performance management means that senior leaders in the tri-borough partnership are very aware of the comparative performance of the services they provide to children.
107. Within Hammersmith and Fulham, the Director of Family Services and senior management team demonstrate a detailed understanding of the specific challenges faced by children and young people in their borough. They know themselves well and have worked effectively to improve services. This has led to the majority of social work practice seen during the inspection being of good quality. Effective assessment of children's needs results in their protection and support from a wide range of services. Children looked after receive a good service, placement stability has improved and their need for permanence is very well identified and met.
108. The local authority identifies areas of service that require improvement and puts effective plans in place to improve and develop the service. The restructure, over the last eight months, of the service for children looked after and care leavers was undertaken to address identified weaknesses in pathway planning and support for young people. The changes made have resulted in improvements in the quality of planning. The local authority has also acted to address weaknesses in the provision of return interviews for young people who go missing from home and from care. Action taken has ensured that the majority of young people are offered an interview with an appropriate person and that interviews are recorded appropriately on young people's files. This is intended to enable the local authority to collate and evaluate the outcome of these interviews more effectively, and to inform further interventions and service planning.
109. Strong oversight by managers of practice means that they can be fully assured that it is of a consistently high quality. Scrutiny of case records by inspectors indicates that management supervision is frequent, regular and evident on the child's file. Records generally evidence a very firm focus on the child. This child-centred approach is strongly supported by the work of innovation-funded advanced and specialist practitioners, and clinicians. All of these highly skilled and well-trained professionals are embedded within the social work teams as part of 'focus on practice' and they add significant value by ensuring that social care services do not have to buy in specialist services at additional expense.
110. Staff feel very well supported, with routine supervision well balanced between casework direction, agreed tasks and personal and professional development considerations. Supervision records seen were mostly good. In a minority, some did not record actions or timescales and only the minority provided evidence of

reflective practice. However, workers have very good access to both formal and informal consultations with a range of expert practitioners, including those working with child sexual exploitation and domestic abuse.

111. Performance management is significantly enhanced by the use of highly innovative and regular 'practice weeks', which comprise extensive case audits and practice observations undertaken by senior managers. Full participation by professionals from a range of services provides invaluable insight into the actual quality of practice. An extensive overview is delivered of the impact of social work intervention on children's lives. Inquisitive and detailed analysis of the key findings leads to tangible in-borough recommendations to support continuously improved performance. Detailed feedback is provided immediately to social workers. Young people and family members are able to comment on their experiences and the effectiveness of the help and support they have been offered. Areas for improvement are quickly identified and change is swiftly and positively effected.
112. The strategic work undertaken in relation to workforce development has brought increased stability to the workforce over the last 12 months. Effective use of programmes such as 'Step up to social work' and 'Frontline' and the offer of protected caseloads and career development through training, have resulted in large numbers of newly qualified social workers. This has led to a reduction in staff vacancies and turnover, but a relatively newly established workforce in some teams including contact and assessment and family support and child protection, where some 40% of social workers are in their first year of practice. Action has been taken to improve support and capacity to deliver services for children, with additional posts created to maintain low caseloads.
113. A dedicated and talented specialist team operates to a well-established and highly coherent model of commissioning, including joint commissioning. Significant additional resources have been drawn down to support services in a very wide variety of ways, using collaborative commissioning techniques. The demographics of the tri-borough partnership mean that commissioners can draw on trust funds, philanthropic giving and social enterprises to a greater extent than in other areas. Tri-borough commissioners are therefore exceptionally skilled at brokering additional resources and using these to add considerable value to existing services. Tri-borough commissioners are also highly active in shaping resources to meet identified need. They have very efficiently decommissioned and re-commissioned some services, such as semi-independent living for care leavers.
114. Links with the health and well-being board are underdeveloped and children's needs are not well identified or addressed in the current priorities and strategy. This represents a missed opportunity by the local authority to fully engage broader partners and commissioners in helping to meet the needs of vulnerable children and young people in Hammersmith and Fulham.

115. A strong emphasis on resolving dissatisfaction at an early stage means that formal complaints are relatively low in number across the tri-borough partnership. Social workers, activity officers and participation workers across the tri-borough partnership build meaningful relationships with children and families, and work hard to resolve any dissatisfaction at an early stage, before it escalates into a more formal investigation. Robust advocacy arrangements ensure that children and young people are well supported and helped to articulate their complaint. Complaints literature for children and young people has been reviewed and refreshed to ensure that the complaints process is better promoted and more easily understood. Thorough analysis of complaints and compliments effectively informs the learning and improvement framework, in recognition that learning from complaints is an important element of service development. Individual annual complaints reports for each borough appropriately reflect differing learning outcomes across the tri-borough partnership. Detailed training is successfully delivered to all managers and staff on effective handling of complaints. Children and young people are regularly consulted on six themes linked to the children looked after strategy, so that they can inform service improvement and delivery.
116. The consistently high quality of pre-proceedings work across the tri-borough partnership means that social workers attend court having undertaken all necessary assessments to support robust and well-resourced care packages. Rigorous placement finding is very well supported by a comprehensive sufficiency strategy, with clear links to the joint strategic needs assessment prepared by Public Health. Evidence to support care plans is consistently robust and includes appropriate and thorough consideration of family members. This significantly minimises delay in children looked after achieving the best possible plan for permanence. Positive relationships with Cafcass enable meaningful dialogue and challenge where differences arise and, as a result, all issues identified are effectively and quickly resolved. Joint quarterly reviews of cases of children looked after in proceedings by senior managers give them the opportunity for challenge and learning to improve services.
117. An effective Children in Care Council (CiCC) has a real focus on informing and influencing the discussions and decisions at the corporate parenting board. Care leavers report that the CiCC has greater effectiveness than in previous years. Examples of impact in changing or developing services include the development of an 'app' to improve participation for young people (MOMO) and being involved in consultation for the new semi-independent accommodation framework. The corporate parenting board has a knowledgeable and committed approach with appropriate levels of scrutiny and positive engagement with young people, who have effectively raised their awareness of important issues. Areas identified for further development include developing apprenticeships, work experience and mentoring.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is good

Executive summary

Overall, amalgamation under a single LSCB creates significant benefits for young people and for all partner agencies. These include rationalisation of time, the secure involvement of senior representatives from partner agencies, many of which span several boroughs, pooling resources to tackle issues in common and alignment with tri-borough children's services. The tri-borough achieves the right balance between shared and local functions, and this ensures that children are safeguarded effectively.

Robust links are in place between the LSCB and other statutory bodies and this allows the board to make sure that children's safeguarding stays high on everyone's agenda.

Extensive engagement by partner agencies has been secured and the work of the LSCB is therefore well resourced through partners' financial contributions. The board's business support team would benefit from a work plan to sit alongside the board's business plan and drive through the priorities for children.

Through systematic analysis of audits under Section 11 of the Children Act 2004, the LSCB has assured itself that safeguarding is a priority for all partner agencies. The board's quality assurance sub-group effectively monitors multi-agency safeguarding performance across the tri-borough partnership. Detailed analysis of data is routinely undertaken by the sub-group and reported to the board by exception, although the board would benefit from a review of this process to assure themselves of its effectiveness. Actions arising from reviewing data lie with individual partner agencies and no system is in place to monitor whether actions identified are carried through.

The board has systematically undertaken rigorous multi-agency themed audits. These audits provide appropriate recommendations for change, but further checks have not taken place to establish whether practice has actually changed or improved.

Effective monitoring by the child sexual exploitation and missing sub-group enables the board to have a robust understanding of missing children and their behaviour across the tri-borough partnership.

An established case review sub-committee ensures that lessons learned from reviews are disseminated promptly across the tri-borough partnership. The sub-committee has clear action plans in place for each individual case review but does not have an overall action plan to cover their ongoing work.

A clear and detailed learning and improvement framework incorporates the learning

from serious case reviews, themed audits and performance monitoring by the board. The learning and development sub-group of the LSCB undertakes its role across the tri-borough partnership and ensures that sufficient safeguarding training is provided across all partner agencies. However, no formal analysis of the impact of training takes place, either across the tri-borough partnership or at borough level.

A wide range of activity to tackle the board's priorities and any lessons from SCRs is appropriately included in the LSCB annual report. An attendance log shows that some members have infrequent attendance, but no challenge is evident. A comprehensive safeguarding plan covers all of the board's priorities.

Recommendations

118. Review the extensive dataset to ensure that it is aligned to the board's priorities.
119. Devise a system for ensuring that actions arising from data scrutiny are carried out in the individual boroughs.
120. Ensure that recommendations from multi-agency themed audits are carried out and analyse their impact on improving practice.
121. Develop an overarching SCR action plan to track the progress of work arising from individual case reviews.
122. Devise a system to escalate concerns about infrequent partnership attendance at the board.

Inspection findings – the Local Safeguarding Children Board

123. Local Safeguarding Children Board (LSCB) arrangements are effectively shared, and almost all of the statutory functions of the LSCB and its sub-groups are delivered across the tri-borough partnership. Each borough appropriately maintains a local LSCB partnership group, and this ensures that local safeguarding issues are suitably considered and reported on to the LSCB.
124. Governance arrangements between the LSCB, other key strategic bodies, elected members and chief executive officers in each of the respective bodies have been effectively developed by the board and are clearly documented. The independent chair links frequently with the Director of Children's Services (DCS) for the tri-borough partnership, while remaining appropriately independent. Key LSCB representatives, such as the DCS, are able to ensure that safeguarding children issues are considered across strategic boards, and that elected members are engaged in the local LSCB partnership groups. The independent Chair meets with the chief executives of each borough at least annually. However, this minimal involvement does not provide them with detailed

oversight of safeguarding within boroughs. The independent chair operates across the tri-borough partnership, and this limits the time available for maintaining links with key elected members and strategic partnership groups, such as the health and well-being boards.

125. The independent chair of the LSCB, who is long-established in the role, actively promotes safeguarding issues across the partnership and community, and provides appropriate challenge. As a result, extensive engagement by partners has been secured across the full range of safeguarding work. Partners are encouraged and enabled by the chair to raise issues and challenges constructively. This is well evidenced in the minutes of the board and its sub-groups.
126. The operational work of the board is well-supported. Each of the key partners appropriately provides financial contributions, and these fund the business support team for the board. The team is actively involved in enabling community and service user involvement in the board's work. The LSCB was able to demonstrate the involvement of young people in developing publicity material, but acknowledges that the engagement of young people in helping to develop its work could be further enhanced. Over the past year, there have been several changes of the business manager post-holder, and recently a new manager has been seconded to the post. While this has not negatively impacted on the support provided to the board, a business plan to coordinate the activities of the business support team and the work arising from LSCB and its sub-groups is not evidently in place.
127. The LSCB has effectively ensured that safeguarding is a priority for all partner agencies. A biannual cycle of audits under Section 11 of the Children Act 2004 is currently being renewed. The board has developed and piloted a bespoke, online self-assessment tool that is currently going live. Previous returns have been systematically analysed and reported to the board. Schools, in particular, are actively engaged and represented in the work of the board, as is the full range of health partners, police and representative voluntary sector organisations.
128. The quality assurance group of the LSCB oversees partners' multi-agency safeguarding performance across the tri-borough partnership. It draws on both qualitative and quantitative data, and is supported by the tri-borough performance team in compiling data into a detailed, high-quality performance report. Partner agencies now contribute to the dataset, which was initially extensively based on local authority children's services data. However, the LSCB has not systematically reviewed this extensive dataset to ensure that this is refined, aligned to its priorities and manageable (Recommendation).
129. The dataset reported upon sufficiently enables the LSCB to interrogate its key safeguarding functions. Detailed analysis of the data is routinely undertaken by the sub-group and reported to the board, drawing out themes and trends. Partners provide commentary on the data supplied to clarify and add context to

- it. The group's report to the LSCB is by exception, identifying issues that the board may want to interrogate further. Responsibility for actions arising from the scrutiny of data lies with individual agencies, but no system is in place to monitor whether actions identified are carried through (Recommendation).
130. Partners on behalf of the board have systematically undertaken a varied programme of multi-agency themed audits. These are appropriately selected in response to key issues arising from quality assurance, data analysis, or to inform short-life working groups. These facilitate learning and identify key areas for improvement in services. For example, a focused audit of young people at risk of sexual exploitation identified effective practice through the involvement of systemic family therapists. While the multi-agency audits provide recommendations for change, further auditing of the themed issues has not been undertaken to enable the LSCB to know whether practice has actually changed or improved as a result (Recommendation).
131. The child sexual exploitation and missing sub-group of the LSCB effectively monitors information on children who go missing, and this enables the board to have a robust understanding of missing children and their behaviour across the tri-borough partnership. The missing person coordinator provides weekly information on missing children, and ensures that this information is updated by operational workers. The coordinator maintains lists of both the top 10 missing young people across the tri-borough partnership, and the top 10 within each borough. This data is suitably analysed through a quarterly meeting, where reductions or escalations in missing episodes are discussed. Through this close analysis and weekly monitoring, the sub-group is aware that only a small number of young people are involved in the majority of missing episodes. This enables those young people to be closely monitored and targeted work to be undertaken with them to minimise risk. Through careful monitoring, the LSCB has a clear picture of the profile of child sexual exploitation and offending across the boroughs. Data mapping has helped to build a picture of hotspots. All this information, as well as information on new cases, is fed into the multi-agency sexual exploitation meeting and the LSCB. This ensures that the LSCB has a clear understanding of child sexual exploitation, its profile, offenders, victims, and the quality and effectiveness of services, as well as the hotspots and places of concern.
132. An established case review sub-committee across the tri-borough partnership has a balanced representation from all agencies, including representation of voluntary services and the police. It has appropriately recommended timely commissioning of serious case reviews (SCRs) to the LSCB, and these have been conducted with a suitable focus on the lived experience of the child. The majority of reviews undertaken in recent years were completed within realistic timescales, and where there have been delays due to external constraints, for instance due to criminal proceedings, the sub-committee ensures that emerging lessons learned are shared prior to completion, to swiftly improve practice.

133. The LSCB ensures that lessons from reviews are shared as well as outcomes, and that these are disseminated promptly across the tri-borough partnership, regardless of their borough of origin. A detailed and succinct summary of lessons learned is circulated on a quarterly basis to all agencies and staff to promote awareness, with a representative of each agency tasked to ensure its distribution. The learning and development business manager is part of the case review sub-committee and this helps to ensure that priority is given to training needs identified as a result of SCRs, and that adjustments to training materials are made and cascaded to all multi-agency partners. The lead designated officer for the tri-borough partnership uses her extensive networks with other boroughs well, so that statutory safeguarding training reflects current practice.
134. Significant cases that do not reach the thresholds for, or are outside the scope of, a serious case review are still reviewed, with a number of significant lessons learned. The board carefully reviews the criteria for SCRs and, where necessary, will commission one even where formal thresholds are not met, where it is considered that lessons can be learned. The impact of SCRs is evaluated through case file auditing to check for the positive application of lessons learned.
135. Challenges identified by the SCR sub-committee align well with those faced by frontline workers, including tools to identify and assess early neglect, the quality of intervention in domestic violence, and issues around the mobility of abusive families. A wide range of methods are used to highlight and follow up identified themes and issues with all partners, including a useful website, additional community work and regular meetings with school improvement advisers. The sub-committee has good, close relationships with the three partnership boards to share themes and provide advice to improve practice. The sub-committee has clear action plans in place for each individual case review, but does not have an overall action plan to cover their ongoing work (Recommendation).
136. The child death overview panel (CDOP) undertakes its statutory duties effectively across the tri-borough partnership. It is well attended and chaired. Members are well informed and demonstrate a clear understanding of trends in local child deaths and the reasons for these. The number of incidents across the tri-borough partnership is relatively low, with 23 reviews last year. As a result, there is no disaggregation of data by borough, although work is commencing with other CDOPs across north-west London to gain a fuller picture. Research undertaken into sudden unexplained death led to training for professionals, and awareness-raising around issues such as co-sleeping. A clear understanding of issues relevant to the area, such as deaths in private hospitals, abroad and in older children, has all led to further work to drill down and understand the issues and helped to prevent further deaths. For example, work around vulnerabilities linked to death by stabbing. Social Care Institute of Excellence methodology has been used to undertake learning reviews in some

cases, with lessons appropriately disseminated, and this has been shown to be having a positive impact on practice.

137. The CDOP produces an annual report, and this is suitably considered by the LSCB. The most recent report's main theme was related to perinatal and neonatal incidents, and to life threatening illnesses. A review of the neonatal deaths was undertaken, and concluded that good care was provided. The report appropriately provides a breakdown by age and ethnicity, and some analysis of the issues.
138. A clear and detailed learning and improvement framework has been developed, implemented and recently reviewed by the LSCB. This has incorporated the learning from serious case reviews, themed audits and performance monitoring by the board. The learning and development sub-group of the LSCB undertakes its role across the tri-borough partnership and it ensures that sufficient mandatory safeguarding training is provided across all partners, both on a multi-agency basis and within individual partners' training programmes. All key voluntary and statutory partners are represented on the sub-group, and they are actively engaged in delivering, as well as developing, training. The group has maintained core safeguarding training, while developing or updating training modules in response to current, high-profile safeguarding issues. For example, a practice sharing conference on 'Prevent' for schools has been developed and is being followed up by similar events on child sexual exploitation and neglect. The training has led to increased referrals from schools, and early years settings are also contacting 'Prevent' teams for training. Partners, particularly the voluntary sector, receive regular information and access to safeguarding training.
139. Members of the learning and development sub-group are fully aware of the need to further develop its work and continually raise awareness of the LSCB. The sub-group has identified the need to undertake a more systematic evaluation of the impact of the extensive safeguarding training provided through the LSCB. Currently, the sub-group primarily bases its evaluation of training on self-reporting attendee questionnaires immediately following training sessions. Plans to develop this will require attendees to complete questionnaires three months after the training, to evaluate what difference the training has made, but these are at an early stage. At the time of this review, there was too great a reliance on anecdotal information, and no formal analysis of the impact of training either across the tri-borough partnership or at borough level.
140. Most training continues to be provided during the daytime in traditional classroom or conference-type environments. For some partners, releasing staff to attend this type of input is a challenge, and the sub-group has developed some more flexible sessions, for instance to enable police officers to attend. However, the provision of a wide range of e-learning modules, to improve access to training, has been delayed by internal technology challenges.

141. The LSCB has ensured that the needs of key vulnerable groups of young people are systematically reported to, and considered by, the board. It has been proactive in supporting and developing a number of safeguarding services. For example, the LSCB has supported a pilot project to tackle female genital mutilation, an identified gap in services. As a result, 68 women have been supported in the last year through early help, and others through child in need or child protection plans. The board has been instrumental in the development of the harmful practices project, which also reports into the existing violence against women group. This tri-borough project tackles harmful practices such as forced marriage, honour-related violence and faith-based abuse.
142. The highly effective neglect subgroup was formed as a short-life working group following analysis of the high prevalence of neglect as a category for child protection plans. The multi-agency group extensively reviewed research, SCRs and direct work tools. It then completed a case file audit and established the most effective method of working with families to fit with existing structures, working practices and local need. A further aim of the group is to raise awareness among practitioners. The toolkit subsequently developed highlights the lived experience of the neglected child and is currently being trialled for effectiveness by early help practitioners and social workers. Early indicators have shown that it creates a focus on the child rather than the family, and that parents have embraced this way of working. An awareness-raising conference is currently being planned for May 2016 in partnership with the NSPCC. This will form the start of a campaign that aims to ensure that awareness of neglect reaches all services within the voluntary and statutory sectors. Effectiveness will be measured through various means, such as a re-audit of case files, increased consultation on neglect issues, both within partner organisations and with social care, and also a reduction of children on a child protection plan under neglect, in the longer term.
143. The LSCB annual report describes a wide range of activity that has taken place to tackle the board's priorities, and lessons from SCRs are appropriately included. However, the report does not provide a rigorous and transparent assessment of safeguarding across the tri-borough partnership. Each priority has a 'what difference has it made' section, although the section is more process or action based, rather than evidencing outcomes for children. The report attempts to understand the population across the tri-borough partnership and the differences between them, although there is little analysis of this. No safeguarding data are presented in the report, and it does not detail any challenges and demonstrate the impact of these. An attendance log shows that some members have infrequent attendance, but there is no challenge to this outlined in the report (Recommendation).
144. A comprehensive LSCB safeguarding plan suitably covers all of the board's priorities. All actions have a lead organisation or sub-group attached, although there are no timescales for completion of those actions. The description of the evidence of impact is, in places, more outcome-focused than the business plan, although this could be further improved.

145. A wide-ranging membership and good attendance ensure that the Hammersmith and Fulham partnership board effectively identifies local issues and barriers to partnership working, and shares information on safeguarding concerns.
146. A valued and effective core function of the group lies in its networking. All partners can describe strong examples of the difference the group makes to children's and families' lives. For example, concerns around threats of sexual exploitation to young people in alternative school provision.
147. Agencies effectively challenge each other on their responses to safeguarding issues, and this helps to support learning and to remove barriers to effective safeguarding. For example, the recent challenge to health partners to follow up pregnant homeless refugees.
148. The chairs of each partnership board meet regularly to share information and are using the individual boroughs well to trial potential new ways of working. For instance, introducing questionnaires to assess the impact of training on practice. The partnership board recognises that an area for development is to bring the voice of the child more into information sharing and decision-making processes.

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 six of Her Majesty's Inspectors (HMI) from Ofsted, an additional inspector and a local authority seconded inspector.

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