London Borough of Bromley

Inspection of services for children in need of help and protection, children looked after and care leavers

and

Review of the effectiveness of the Local Safeguarding Children Board[1]

Inspection date: 11 April 2016 to 5 May 2016

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Children's services in Bromley are inadequate		
1. Children who need help and protection		Inadequate
2. Children looked after and achieving permanence		Inadequate
	2.1 Adoption performance	Inadequate
	2.2 Experiences and progress of care leavers	Inadequate
3. Leadership, management and governance		Inadequate

[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

There are widespread and serious failures in the services provided to children and families in Bromley. Senior leaders and managers do not have a comprehensive understanding of the strengths and weaknesses of the services that they provide for vulnerable children and young people. Since the Ofsted inspections of 2010 and 2012, there has been significant deterioration in services for children's safeguarding, children looked after, care leavers and children requiring adoption.

This is a corporate failure by the local authority that leaves too many children in neglectful and abusive situations for too long. Weak practice includes the poor identification and reduction of risk, a lack of understanding and application of thresholds, and cases stepped down too soon from child protection to child in need on insufficient evidence that progress is being made or sustained. Some children wait too long before becoming looked after and there is a lack of urgency in progressing permanency plans.

Senior managers do not have sufficient understanding of the issues to take appropriate action to improve performance and practice. Oversight of cases is weak, ineffective and not systematic. Performance management information is used insufficiently to improve practice. Quality assurance arrangements are inadequate and case auditing does not demonstrate rigour to review the quality of work. Independent reviewing officers (IROs) and conference chairs do not provide sufficient challenge to frontline social workers or their managers. Neither are they sufficiently robust in escalating concerns.

The response to children missing or at risk of child sexual exploitation is inconsistent and uncoordinated. The local authority lacks understanding about the prevalence or level of risks for individual children and young people, and their collective profile.

There is evidence of better practice in early help services through the Bromley children's project, where the work of family support is well embedded. Assessments for early help intervention are timely and lead to a range of appropriate services. The borough commissions an extensive range of effective early help and statutory services for children and families.

An appropriate range of colocated professionals work effectively together in the multi-agency safeguarding hub (MASH). Roles and responsibilities are well understood, and referrals to children's social care are dealt with promptly.

Those children and young people who need to be looked after wait too long before coming into care. Some children experience significant delays in decision making before plans for permanence are progressed. Comprehensive weaknesses in the quality of legal advice mean that local authority lawyers are not sufficiently experienced to advocate for children in complex care proceedings. Cases are not prepared thoroughly enough for court, and social work evidence is too often not

strong enough to support the local authority's plan.

There is a lack of urgency in progressing permanency plans. Not all children are considered for adoption when they are unable to return to their birth parents, and many are not considered soon enough. This means that too few children are adopted and, for those that are, the process takes longer than is necessary.

Good arrangements are in place to maintain and improve the health of children and young people looked after. The designated nurse, located within the looked after social work team, helps to ensure a coordinated approach to children's and young people's health. There is good support for their emotional health and well-being through dedicated looked after children and adolescent mental health services (CAMHS) provision.

The majority of children looked after are placed within good-quality foster placements and receive a good level of support from their carers. Most children looked after go to a good or better school, and personal education plans are generally of a high quality as a result of effective work undertaken by the virtual school. The virtual school team knows the circumstances of individual children well. It routinely monitors their progress, including the progress of those children and young people causing concern and that of those who are living outside of the borough.

The local authority recognises that it does not have sufficient foster placements for older children, and for children and young people from an ethnic minority background. Proposals to change allowances for foster carers are having a negative effect on the local authority's ability to retain foster carers.

The current Living in Care Council (LinCC) is representative of the diverse needs and circumstances of children looked after. It is well supported by dedicated participation and engagement workers to express their views, and to influence service quality and development.

There is an insufficient range of safe and suitable housing available for care leavers. The local authority routinely places a significant number of care leavers in bed and breakfast accommodation, which is not appropriate. As such, arrangements are not risk assessed and managers cannot assure themselves of the safety of young people. Local authority staff do not effectively engage with more challenging young people who are reluctant to take up offers of help.

For those children and young people with disabilities, a clear referral pathway ensures effective joint working with safeguarding, and referral and assessment teams, when there is a concern.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates no children's homes.
- The last inspection of Bromley's arrangements for the protection of children was in July 2012. The local authority was judged to be adequate.
- The last inspection of Bromley's services for children looked after was in April 2010. The local authority was judged to be adequate.

Local leadership

- The interim director of children's services (DCS) has been in post since October 2015.
- The chair of the LSCB has been in post since April 2015.

Children living in this area

- Approximately 71,500 children and young people under the age of 18 years live in Bromley. This is 24% of the total population in the area.
- Approximately 15.5% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 11.4% (the national average is 15.6%)
  - in secondary schools is 8.4% (the national average is 13.9%).
- Children and young people from minority ethnic groups account for 15.9% of all children living in the area, compared with 14% in the country as a whole.
- The main minority ethnic groups of children and young people in the area are Black/African/Caribbean/Black British and Asian/Asian British.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 13.2% (the national average is 19.4%)
  - in secondary schools is 8.5% (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 1 March 2016, 1,785 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 2,258 at 31 March 2015.
- At 1 March 2016, 229 children and young people were the subject of a child protection plan. This is an increase from 220 at 31 March 2015.
- At 1 March 2016, nine children lived in a privately arranged fostering placement. This is an increase from six at 31 March 2015.
- Since the last inspection, one serious incident notification has been submitted to Ofsted and one serious case review has been completed or is ongoing at the time of the inspection.

Children looked after in this area

- At 1 March 2016, the local authority was looking after 281 children (a rate of 39.8 per 10,000), an increase from 265 (37 per 10,000 children) at 31 March 2015.
  - 147 (or 55.9%) live outside the local authority area
  - 21 live in residential children's homes, of whom 18 live outside the authority area
  - eight live in residential special schools,[3] all of whom live outside the local authority area
  - 192 live with foster families, of whom 84 live outside the local authority area
  - three live with parents, one of whom lives outside the local authority area
  - 16 children are unaccompanied asylum-seeking children.
- Since 1 April 2015:
  - 19 children have been adopted
  - 12 children became subject to special guardianship orders
  - 119 children ceased to be looked after, of whom 4.2% subsequently returned to be looked after
  - 23 children and young people ceased to be looked after, and moved on to independent living
  - four children and young people ceased to be looked after, and are now living in houses of multiple occupation.
- The local authority uses 'signs of safety' as its social work model for child intervention work.

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

Recommendations

1. Ensure that the director of children's services has the authority and capacity to respond to deficits in children's and young people's services, and to drive forward change and improvement.

2. Review and improve all quality assurance arrangements to ensure that senior managers and elected members understand performance, in order that they may robustly improve the quality of social work practice.

3. Improve management oversight of frontline practice to ensure that decision making, assessment and planning for children and young people is both timely and focused to meet their needs. This is to include the work and involvement of conference chairs and independent reviewing officers.

4. Review workforce capacity in order to reduce social work caseloads in the referral and assessment, and safeguarding teams, to enable staff to carry out good-quality direct work with children.

5. Ensure that thresholds are understood and consistently applied in response to risk, so that appropriate actions are taken when risks or concerns escalate or diminish.

6. Ensure child protection, child in need, children looked after and pathway plans are informed by assessment, focused on the needs of individual children and young people, and specific about the outcome to be achieved and the timescale for change. Contingencies should be explicit.

7. Improve the arrangements to reduce the risk to children of sexual exploitation and episodes of missing from home and care, by:

   - ensuring that risks to sexually exploited children and young people, and those who go missing, are routinely assessed and understood by strategic managers who take timely action to address concerns

   - developing suitable arrangements to share and analyse information from child sexual exploitation risk assessments and 'return' interviews to reduce future risks for individual children and young people, and to inform partnership prevention and disruption activity.

8. Review the cases under the public law outline and in care proceedings to ensure that robust plans are in place and that cases are progressing at a pace that matches children's needs.

9. Improve the quality of legal advice to social workers and their managers to enable confident and effective presentation of care plans in court, to achieve the right outcomes for children and young people.

10. Ensure priority is given to considering achieving permanency, including adoption, at the earliest possible point for children, and that there are effective systems to track and monitor the progress of this work.

11. Improve the sufficiency and choice of placements within the borough to meet current needs, to strengthen placement planning arrangements and to ensure increased support to foster carers.

12. Ensure that robust assessments are undertaken when considering alternative permanency options for children with connected persons.

13. Ensure that children and young people who are placed out of the borough are sufficiently supported by their social worker and have access to services to meet their needs where they are living.

14. Ensure through direct work with children that they have the opportunity at their own pace to explore their history, identity and reason for becoming looked after, and that their voice is heard in plans which affect them.

15. Ensure that children looked after in Year 12 are effectively supported and encouraged to remain in education.

16. Increase the range of suitable accommodation available for homeless 16- and 17-year-olds and care leavers, so that they are safe and feel safe where they live.

17. Integrate children's commissioning arrangements corporately, to ensure that safeguarding children and young people is understood and prioritised.

18. Evaluate services that support children and families living with domestic violence, drug and alcohol misuse and parental mental ill health to ensure that these are making a difference and improving circumstances for children and young people.

Summary for children and young people

- Senior managers and leaders in Bromley do not have a good understanding of what works well to protect vulnerable children and young people. Since Ofsted last inspected Bromley, services have got worse for children and young people.
- The local authority has not given enough help to children in care and those who need to be adopted. Social workers are too slow at finding permanent places for children and young people to live.
- Senior managers do not ensure that staff receive appropriate support and guidance. This is important to ensure that staff make the right decisions about children's and young people's lives.
- Children and their families receive the help that they need quickly when they first approach Bromley for support. A good example of this is the Bromley children's project.
- Managers in Bromley do not get good enough legal support in court. Because of this, childcare cases are not well prepared and do not always support plans for children's and young people's futures.
- Children who are looked after by the local authority live healthy lifestyles and do well in their education. Staff work closely with health and educational professionals to help children and young people to do well with their studies and to stay healthy.
- Children looked after receive good-quality care while living with foster carers. Leaders and managers understand that they need to recruit more foster carers and they will need to work hard to keep the current number of carers who foster children and young people for Bromley.
- The Living in Care Council (LinCC) meets often with senior managers and leaders, who listen to and take its views and opinions seriously. This helps to shape children's services, taking into account the things that children and young people would like to see happen.
- There is a lack of safe and suitable housing available for care leavers. The local authority regularly places these young people in bed and breakfast accommodation, and this is not appropriate.

The experiences and progress of children who need help and protection	Inadequate

Summary

Services for children in need of help and protection are inadequate. Serious and widespread weaknesses in the identification and management of risk to children and young people mean that the local authority is failing to ensure that the most vulnerable children in need of help and protection are safeguarded. Such failings are characterised by weak managerial oversight, and the absence of authoritative and timely casework interventions. This contributes to drift and delay in too many cases. Thresholds are neither consistently applied nor understood, and cases are stepped down too soon from child protection to child in need on insufficient evidence of progress being made or sustained.

Senior managers do not have sufficient understanding of the issues to take appropriate action to improve performance and practice. Other managers neither set clear actions and timescales for social workers, nor provide sufficient review and challenge. This means that plans are not progressed as quickly as they should be, and children and young people are left in neglectful and abusive situations for too long. Child protection chairs do not provide sufficient challenge and scrutiny to ensure that plans are effective in keeping children safe.

Of the cases considered by inspectors, none was compliant with statutory guidance. Strategy discussions are not held soon enough and, in the majority of child protection and child in need plans, the presenting risks do not fully inform the plan, and actions are not specific enough and lack clarity about the outcome to be achieved.

The identification of risk is not always prominent in the majority of assessments, which are too descriptive and lacking in analysis. Insufficient weight is given to children's histories, and chronologies are poor and incomplete. Tools to consider neglect and assess and understand risks are underutilised.

Roles and responsibilities are well understood in the MASH, and referrals to children's social care are dealt with promptly. Early help intervention through the Bromley children's project and the work of family support is well embedded. Early help services offer a range of effective support services for children and families.

The response to children missing or at risk of child sexual exploitation is underdeveloped, inconsistent and uncoordinated. Delays in police notifications mean that it is not clear when children first go missing and when they return.

Homeless 16- and 17-year-olds are sometimes placed in bed and breakfast accommodation, which is unacceptable practice.

Inspection findings

19. The application of thresholds, and the identification and management of risk are inadequate in Bromley. In cases seen by inspectors, risk is not consistently recognised, and past history and concerns are given insufficient consideration. In too many cases when risks have escalated, the local authority has not had the confidence to intervene robustly and in a timeframe that is optimal for children and young people. At the time of the inspection, 12 children had been subject to a child protection plan for over two years, seven of whom are in care proceedings. In these cases, parents have failed to engage in assessment and with support services to reduce risk. Children have been left in neglectful situations by the failure of the local authority to convene or review timely legal planning meetings and to consider public law outline procedures soon enough. This is clearly detrimental to their welfare. (Recommendation)

20. Child protection cases are stepped down too soon to child in need, with insufficient progress made in key areas at the point of transfer. For example, in some cases, parents have only just started to engage in work to address domestic violence or drug and alcohol misuse, and their ability to change and to sustain improvement has not been tested. Cases seen where risks had escalated were appropriately stepped up from child in need to child protection. The number of children subject to repeat child protection plans has risen significantly from 13% in 2014–15 to 21% currently, which is well above comparators. For this group of 48 children, the previous plan has closed too soon or the work completed has been ineffective. This means that children's and young people's safeguarding needs are not met in a timely or comprehensive manner. (Recommendation)

21. Strategy discussions are not being held soon enough when concerns are first identified, and are not compliant with statutory guidance. All strategy discussions are solely between police and children's social care, without direct involvement by health or other agencies, despite a range of multi-agency professionals being present in the MASH. Professionals contribute information, but are not actively involved in decision making and the planning of section 47 enquiries. This means that important child protection decisions are not informed by the widest possible range of multi-agency views and information available.

22. As a result of an audit of MASH contacts in September 2015 that identified a lack of formally recorded discussion with partner agencies, the use of conference calls is being explored to improve effectiveness. It is too early to measure the impact of this proposed initiative.

23. Numbers of strategy discussions, section 47 enquiries and initial child protection conferences remain lower than comparators. The local authority has not undertaken sufficient analysis to understand the reasons for this. The proportion of initial child protection conferences completed within 15

days of the decision to begin an investigation has improved on the previous year, from 67% to 83%. Review conferences are timely, with the local authority reporting a current performance figure of 96%.

24. Some more recent assessments demonstrate effective use of the local authority social work model, but others are too descriptive and lack sufficient analysis. In stronger cases, children's and families' views are clear and include a thorough assessment of risks with clear actions. In weaker cases, tools to consider neglect and assess risks are underutilised. Chronologies do not provide a succinct and clear history to inform assessments. The individual needs of children and young people are routinely considered together in a single assessment. This means that the individual needs of children and young people are not clearly recognised and are in danger of becoming lost. Research is rarely used to inform analysis in assessments.

25. Although not evident in all cases, inspectors saw evidence of some direct work with children. Tools such as 'three houses' are used to engage children and to elicit their views, which are reflected in the assessment. The use of words and pictures in one case helped a child to understand the worries of professionals and what is to happen to ensure the child's safety and well-being.

26. Young people aged 12 years and over are routinely asked if they would like the services of an advocate to assist in their views being considered. Support is provided to parents and young people by an externally commissioned advocacy service. Between November 2015 and January 2016, this service supported 29 young people to attend initial or review child protection conferences. Inspectors observed child protection conferences where advocates sensitively engaged and supported children and parents to ensure a clear understanding of the seriousness of the concerns.

27. The majority of child protection plans and child in need plans are not specific enough and, in too many cases, risks do not inform the subsequent plan. In most cases, it is not clear what outcome is to be achieved and by when. For example, despite a positive parenting assessment, it was recommended that a mother attend a parenting course, yet the plan did not specify what areas she needed to work on and why. Parents spoken to during the inspection showed an understanding of the local authority's concerns, but were not always clear about what changes they had to make to address these. Brothers and sisters being considered together on shared plans inhibits the identification of individual children's needs. Contingency planning is not specific enough for families to understand the consequences, if progress is not made to address child protection concerns. (Recommendation)

28. Bromley commissions a number of services to assist families where domestic violence, substance misuse or parental mental ill health cause concern. This includes Bromley adults' substance misuse service, victim support services and Bromley and Lewisham MIND, an organisation that works alongside

people with mental health needs and dementia. During the past year, conference monitoring has shown that, of 457 conferences, domestic violence has affected 279 families, mental health 170, alcohol misuse 136 and drug misuse 158. Too often, plans recommend parents' engagement or re-engagement with services without considering how effective these services are. (Recommendation)

29. Managers do not set clear actions and timescales for social workers, and do not provide sufficient review and challenge. This means that plans are not progressed as quickly as they should be. Child protection chairs do not provide sufficient challenge or scrutiny and, in the past year, have only escalated 10 cases for formal resolution. (Recommendation)

30. Child in need cases are not considered within the monthly performance digest, as this data is not systematically captured. Instead, cases are recorded on individual managers' spreadsheets. This means that the local authority does not have reliable data to assist managers to oversee the quality and timeliness of work within these cases, to monitor trends or to understand the profile of this group of children and young people. (Recommendation)

31. High numbers of cases for the social workers in the referral and assessment, safeguarding and care planning teams inhibit high-quality social work. Some social workers with 25 or more cases report that they do not have sufficient time to undertake positive direct work with children and families, or to reflect with managers on the progress of their work. (Recommendation)

32. Children who go missing or who are at risk of child sexual exploitation receive an inconsistent response from agencies. Delays in notifications from the police mean that children's social care is not always aware at what point children go missing or the date when they return. This means that the offer of a return home interview is delayed, and children may be unable accurately to recall and reflect upon incidents leading to 'missing' episodes. In most cases seen, it was not possible to be assured that a return home interview had been offered or completed. The local authority is currently neither collating nor analysing this data sufficiently well to understand the profile of missing children and the links to child sexual exploitation. (Recommendation)

33. Assessments considered in cases where mothers had undergone female genital mutilation identify concerns appropriately with parents and seek their views regarding this practice. A protocol and update to the threshold document is being developed to support midwives and general practitioners to refer cases appropriately. However, the local authority is yet to collate performance data to ensure that it understands the number and nature of all cases seen.

34. The local authority is more effective in tracking and identifying children and young people missing education. At the time of the inspection, there were

nine children missing education, with staff demonstrating tenacity and determination in locating them. They liaise effectively to undertake relevant checks with other agencies such as revenue and benefits, schools and other local authority services to establish children's whereabouts. Of 199 referrals, only one child could not be traced. Most return to school or join a new school.

35. The local authority has a good understanding of the reasons why parents choose to home educate their children, and holds good information on children's individual circumstances. A multi-agency panel oversees elective home education (EHE). There is effective work between the children missing education officer and the EHE adviser. The adviser undertakes routine home visits and checks on the suitability of the education of the vast majority of children. Effective working with the MASH team and children's social care ensures that children's welfare needs are known. Those children moving into Year 11 after being home educated receive effective help on their next steps from the targeted youth support service.

36. Early help intervention and family support is well embedded and delivered effectively through the Bromley children's project. Thresholds for early help are appropriate and, in the majority of cases, considered as step-up or step-down processes that meet the respective threshold criteria. Assessments for early help intervention are timely and lead to a good range of services being offered. These include an early intervention programme supporting children who have witnessed domestic violence. Five of the six family centres hold early parent education classes, and 'parenting plus' has been offered since March 2015. Family support and parenting practitioners offer a range of workshops and one-to-one support regarding domestic violence, parenting, housing, employment and access to education. Examples of work seen demonstrate that knowledgeable staff assist parents to focus on practical skills and solutions.

37. The early help service has undertaken three common assessment framework (CAF) quality audits during 2015 for primary and secondary schools, health visitors and midwives. All have resulted in appropriate action plans and further review. Consequently, the number of CAFs rose to 706 in 2015 from 603 during the previous year. This was the highest ever figure, and schools completed a third of the CAFs, indicating their commitment to the early help process.

38. The troubled families initiative is reported by the local authority to have been successful, with turnaround of the first 490 families. This has resulted in Bromley successfully achieving targets as part of the Early Start for year one of phase two of the programme.

39. A range of professionals including police, health and education are colocated within the MASH, and all report effective working relationships. Roles and responsibilities are well understood, and referrals to children's social care are

responded to promptly. A shared database ensures that requests for information are followed up swiftly and in priority order, according to risk. Out of normal office hours, the emergency duty team deals effectively with referrals. In cases considered by inspectors, the response was appropriate. The information subsequently passed on to the MASH was detailed and clear.

40. There is evidence that consent is routinely sought, when required, and persistent attempts are made to engage with families to ensure that this takes place. Qualified social workers within the MASH make decisions that are countersigned by consultant practitioners or group managers. Referrers do not always receive feedback following the making of a referral, which does not assist them to contribute to or monitor the progress of cases referred.

41. Multi-agency risk assessment conferences (MARAC) are well attended by a nucleus of key professionals, including from children's social care. Members attend with relevant information, and good joint working ensures that there are effective safety plans. Multi-agency public protection arrangements (MAPPA) meetings are similarly well attended, with agencies reporting an appropriate response from children's social care. Thorough scrutiny of cases identifies risks, and effective joint working ensures that safety plans are established.

42. Sixteen- and 17-year-old homeless young people are assisted by a housing options officer and a housing senior practitioner, who are based part-time in the MASH under a joint protocol between children's social care and housing. Assessments completed are of good quality, with the views of young people, their families, and other agencies being well recorded. Young people are aware of their entitlements as care leavers, and are offered mediation work to facilitate a return home. Young people are also referred or signposted to other support services appropriately.

43. At the time of the inspection, one young person was in bed and breakfast accommodation and had been there for a week with no plan to move on. This accommodation is not thoroughly risk assessed and no additional supports are in place for the duration of this stay. The use of bed and breakfast is an accepted part of Bromley's provision for 16- and 17-year-old homeless young people, yet the local authority is not ensuring that these premises are safe and appropriate. This is a significant failing. (Recommendation)

44. The lack of basic safeguarding practice for children who are privately fostered means that the local authority cannot be assured that they are safe. Not all of the five cases sampled had a completed Disclosure and Barring Service (DBS) check, and in one case the arrangement had been in place for several months. Children from abroad living with host families do not always receive timely visits. Awareness raising regarding private fostering is beginning to have an impact. Within the 'Private fostering annual report

2014–2015' it is noted that, for the first time, the number of notifications from non-language schools and other ethnicities is increasing. At the time of the inspection, there were nine children privately fostered.

45. An effective designated officer and a well-resourced service follow up children who are subject to allegations of professional abuse. Complex strategy meetings are held, when necessary, with clear monitored actions to ensure the well-being and safety of children subject to allegations. Good multi-agency systems and relationships ensure that communication and actions are clear. There is also evidence of training and awareness raising regarding the designated officer role and findings from cases.

46. For those children and young people with disabilities, a clear referral pathway ensures that there is effective joint working with safeguarding and referral and assessment teams when there is a concern. Young people with disabilities are well supported in their transition into adult services.

47. Where there is a risk of a child or young person being radicalised, staff proactively engage with partners in this work. They raise awareness in schools, and successfully intervene to prevent an escalation of concerns. For example, recent cases demonstrate the excellent multi-agency work when the local authority was proactive in taking a matter to court, successfully securing wardships for three children.

The experiences and progress of children looked after and achieving permanence	Inadequate

Most children and young people wait too long before becoming looked after, and authoritative management action is not taken soon enough to safeguard children and young people. Some children and young people have experienced significant delay in being offered help, and there is a lack of urgency to secure permanence for them. There are significant weaknesses in the quality of the legal advice available to social workers and their managers. The public law outline (PLO) process is not used effectively, leading to too many children experiencing significant drift and delay in achieving permanence.

When children do become looked after, their needs are not formally reassessed. Ongoing risk is not always recognised or supported well enough. Care plans for children and young people are not routinely updated and, in many cases, it is difficult to understand what progress has been made. There is limited evidence of social workers carrying out direct work with children and young people, or undertaking life-story work to help them to understand their family history and the reasons for them becoming looked after.

IROs do not provide sufficient challenge to the work of frontline social workers and their managers. They are not robust enough in escalating their concerns. Managerial oversight is weak. There is little evidence of effective scrutiny or challenge to the social work practice taking place to improve outcomes for vulnerable children and young people, including when children and young people return home from care episodes.

Procedures for monitoring and supporting children and young people who go missing from care are ineffective. Risks to children in relation to child sexual exploitation and child trafficking are not well understood. Neither are the needs of unaccompanied asylum-seeking children thoroughly assessed.

Adoption is not considered soon enough for all children who are unable to return to their birth parents. This means that too few children are adopted and, for those who are, the process takes too long. Children wait too long to find permanence, while unrealistic assessments are often undertaken of birth parents and the wider family.

There is an insufficient range of safe, suitable housing available to vulnerable care leavers. They are placed in bed and breakfast accommodation for extended periods of time. The local authority does not know the risks posed to young people by other residents, as these are not assessed.

The quality of foster care is good, and the work of the Living in Care Council (LinCC) is a considerable strength.

Inspection findings

48. At the time of inspection, Bromley looked after 287 children and young people. Inspectors did not find any child for whom the recent decision to become looked after was inappropriate. However, some children who have experienced neglect waited too long before coming into local authority care.

49. Of 287 children looked after and young people, 101 are looked after under section 20 voluntary arrangements. The vast majority (70) of these arrangements are over six months' duration and a further 48 are over 12 months' duration. While the local authority recognised in December 2015 the need to review these arrangements, this review had not taken place by the time of the current inspection. Concerns raised with senior managers during the inspection resulted in the local authority taking action, and a significant number of children's cases were reviewed when it was identified that there was drift and delay. The level of concern was such that the local authority convened an urgent legal meeting to review seven cases, of which one was subject to an urgent legal planning meeting. (Recommendation)

50. The public law outline (PLO) process is not being used effectively to consider what further evidence or assessments are needed to make early decisions about care plans. There are significant weaknesses in the quality of legal advice available to social workers and their managers, and this sets a threshold for intervention that is too high. This results in a lack of confidence in their analysis of risk and professional judgement. Consequently, there are delays in convening and reviewing legal planning meetings, and issuing proceedings. Letters before proceedings do not help to ensure that families are fully aware of the local authority's concerns, expectations and the potential consequences of care proceedings. The length of time to decide care proceedings has risen from 27 weeks to an average of 35 weeks over the past year, which includes one complex case that took 84 weeks. (Recommendation)

51. The local judiciary reports that local authority lawyers are not sufficiently experienced to advocate for children in complex care proceedings. Some lawyers do not prepare cases thoroughly enough before representations in court, and social work evidence is often not strong enough to support the local authority's plan. This results in the court, legal representatives for children's parents and the children's guardians influencing some children's care plans and requesting additional assessments. As a result, some children have experienced significant delay in their care plans being progressed. The local authority's evidence, in a small number of cases, lacks analysis and confident presentation in court. This results in a change of care plan and children being returned to parents when it may not be in their best interests. (Recommendation)

52. Not all children who become looked after have clear and timely pathways to permanence. Senior managers do not consistently authorise assessments

and decisions regarding children and young people returning home to their parents prior to this taking place. This means that the local authority does not know if the risks which led to the child becoming looked after have been ameliorated, or that safe enough care can be sustained. (Recommendation)

53. For those children and young people who require legal permanence through adoption, special guardianship orders (SGOs) or child arrangement orders, there is a lack of urgency in progressing their plan. In a large number of cases there have been delays in holding permanence planning meetings, in one child's case for 14 months after becoming looked after and 10 months after a recommendation from the IRO that it should take place. Similarly, a small minority of children under the age of 10 (16) have been subject to a care order for a number of years, some dating back to 2006, but who have not been considered for permanence. The local authority recognises the need to improve in this area, and in December 2015 it established a performance monitoring process to track the progress of children when they first become looked after. However, this system is very new and underdeveloped, and is therefore not yet having an impact on those children who have been looked after for more than six months. The local authority is yet to demonstrate effective scrutiny and challenge to the quality of social work assessment in relation to permanence planning. (Recommendation)

54. Managerial oversight of practice is a serious area of weakness at all levels. There is no senior manager with a single line of sight or overall responsibility for the progress of all children looked after. There is little evidence of appropriate challenge by group managers taking place to improve practice and outcomes. Managers do not regularly scrutinise children's plans or the impact of social work interventions, and the focus of supervision of social workers is on sharing information rather than the progress and impact of children's plans. (Recommendation)

55. When children can no longer live with their families, approved foster carers meet their needs. Placement stability is better than that in comparator authorities, with only 8% of children having moved placement more than three times in the year. This is an improvement from 2014–15, when it was 11%. The majority of children looked after (61%) are placed with good-quality foster placements. The quality of support that children and young people receive in their placements is good and, to some extent, this mitigates some of the short-term impact of delay in planning for their longer-term needs.

56. The recruitment of foster carers complies with key aspects of regulations. All foster carers had received an annual review which was well recorded and detailed, and this provides evidence of training attended. A good range of training is available for foster carers, as well as a duty system and a well-attended support group, which is positively received. Generally, foster carers spoken to were positive about their supervising social worker. However, many report feeling undervalued by the local authority and do not feel that

they are considered as part of a professional team supporting children and young people.

57. The local authority recognises that it does not have sufficient foster placements for older children and for children from ethnic minority backgrounds. A new recruitment strategy with an accompanying action plan has yet to be implemented. It has been delayed by recent proposals considering the reduction of some foster care allowances. This has created much uncertainty among foster carers regarding their future with Bromley. It is also affecting the progress of children's plans with their current carers and of those children waiting to be matched. These new proposals are having a direct effect on the council's ability to retain foster carers and may affect its ability to recruit, both now and in the future. The local authority has identified that it needs to recruit 22 foster families a year to meet continued demand, although last year it had a net loss of 11 families. (Recommendation)

58. A draft process for finding families has yet to be introduced. However, comprehensive searches are undertaken to ensure a good long-term match for children. This includes the use of Internet profiling and independent fostering agencies where in-house carers cannot meet the needs of the child. The council has 16% of children placed with independent fostering providers and, if the placement is an appropriate match, it is committed to supporting children in these placements long term. Matching reports vary in quality. Most contain information about the child's needs and the skills of the foster carers, although the amount of detail and the level of analysis could be improved. The voice of the child is not clear in most of the reports seen by inspectors. There are delays in long-term matches going to panel when children have been settled in a placement for many months, often well over a year. This makes it difficult to see the foster panel's impact on the quality and timeliness of placement matching.

59. The number of special guardianship orders is decreasing, and 23 children left care on a special guardianship order last year, compared with 12 this year. Some foster carers report that they are reluctant to make an application for children for whom they are caring, because of the lack of clarity about future support, including financial arrangements. Assessments for matching children to connected persons vary in their quality. In most cases, there is a lack of a comprehensive exploration of the risks and vulnerabilities of the placement. When issues arise about a carer's background, there is too often a lack of professional curiosity and insufficient exploration into the impact of this on the carer's ability to meet the needs of the child. Too many reports are overoptimistic about the carer's ability to parent the child into adulthood. The wishes and feelings of children are not often considered in sufficient detail. (Recommendation)

60. The small number of children and young people who live in private residential children's homes outside the borough (21) live in homes that are

judged good or better by Ofsted. However, insufficient checks are made with host authorities as to whether the local area has the appropriate health and education provision required for the child, or whether the placement location presents a child sexual exploitation risk. (Recommendation)

61. The local authority is currently supporting 19 unaccompanied asylum-seeking young people. In most cases, assessments of need and risk are insufficiently robust to ensure that the placements provided are safe and suitable. Issues around culture, ethnicity and religion are recognised by social workers, but are not always fully reflected in assessments or case records.

62. Contact between children and their family members is not sufficiently risk assessed or managed. Insufficient consideration is given to the potential negative impact of very frequent contact and associated travel for children and their attachment behaviour. Contact records are not sufficiently analytical and do not inform case planning well. The local authority has already identified the weaknesses in this service and is undertaking a review.

63. While statutory visits to children are mostly within the local authority's required timescale, it is not clear how visits are contributing to the progress of children's plans. Children and young people do benefit from continuity of social workers within the looked after social work team, and social workers know the children well. However, many children's cases are allocated within the safeguarding and planning service. These teams have experienced a high turnover of staff, with frequent changes of social workers. High caseloads mean that there is insufficient time to undertake this work. (Recommendation)

64. The majority of placement plans seen do not contain the information that carers require to understand the arrangements for children's care. In a small number of cases, carers have not received this information for a number of weeks after children are placed. Placement plans and care plans are not always updated when children move, and delegated authority was not explained or recorded in any placement plans seen by inspectors. (Recommendation)

65. Most looked after children reviews (93.4%) are carried out within the required timescales. IROs do endeavour to see children and young people before their reviews, but this is not always possible for those children who live out of area or some distance from home. Most children are supported to attend their reviews and complete consultation documents. IROs are not always effective in ensuring that children's plans are progressed through the recommendation of specific actions. While they do raise concerns when case planning is drifting, this is not evident in all children's cases and there are too few formal escalations recorded, with little evidence of the difference that this has made for the child or young person. (Recommendation)

66. Although children and young people have access to an independent advocacy service and there is no waiting list, advocacy is not well promoted in children's reviews or by their social workers. However, children looked after do benefit from a well-established independent visitor service. Children reported to inspectors that they value these relationships. Effective processes for responding to children's complaints are in place.

67. Good arrangements are in place to maintain and improve the health of children and young people looked after. All initial and review health assessments and corresponding health plans are carried out by a dedicated community paediatrician. The number of assessments completed within the required timescale has been maintained at last year's rate of 88%. The vast majority of children are up to date with their immunisations (86.8%) and dental assessments (82.6%). The designated nurse located within the looked after social work team helps to ensure a coordinated approach to children's and young people's health. There is good support for their emotional health and well-being through dedicated children looked after CAMHS provision, and currently there are no children or young people looked after waiting for a service. There is ongoing work to develop the use of the strength and difficulties questionnaires that provides an opportunity to identify early concerns about their emotional health. Information for 2014–15 shows that the average score is 14.1, which is similar to comparators.

68. Appropriate support is available to educate children and young people about the risks of drug and alcohol misuse. A single point of access to children's well-being services ensures timely assessment, support and intervention. Two young people successfully completed treatment in the fourth quarter of last year and have maintained abstinence. There are currently no children looked after receiving treatment for substance misuse. Improved working relationships between children's social care, the youth offending service and wider partners have reduced the number of children looked after involved in offending behaviour from 19 in September 2015 to 13 at the time of the inspection.

69. Most children looked after go to a good or better school. Their attendance at school is generally good and compares well to children looked after in similar areas. There have been no permanent exclusions of children looked after since 2008, and the number of those who are subject to a fixed-term exclusion is reducing well. The small number of children placed in alternative provision are generally having their educational needs well met.

70. Personal education plans seen by inspectors were generally of good quality, due to the effective work undertaken by the virtual school to improve the quality of information used to plan children's next steps in education. This helps carers, for example, to take action to support children's specific learning and development needs. The pupil premium is mostly used effectively to support their progress and attainment through individual tuition and, increasingly, to support their social and emotional well-being.

71. The virtual school team knows the circumstances of individual children well and routinely monitors their progress, including those children and young people who are causing concern and those who are living outside of the area. It intervenes quickly where outcomes for children start to decline. As a result, children looked after receive timely and effective help that enables them to stay in school and achieve well. The achievements of children and young people looked after are celebrated on an individual level by education professionals and their carers, and also at an annual celebration evening where children receive recognition for their efforts. This is valued by children and young people, as it promotes their self-esteem.

72. A high proportion of children looked after have special educational needs, and most make good progress from their starting points. In 2014/15, at age seven, a third of children looked after achieved age-related expectations in reading and mathematics, and half did so in writing. Most make the progress expected of all children between the ages of seven and 11, when nearly two thirds achieve age-related expectations in English and mathematics. The progress that they make from age 11 to 16 is significantly better than children looked after nationally. In 2014/15, a quarter of 16-year-olds achieved five GCSEs including English and mathematics. These are the best results ever for children looked after in Bromley, narrowing the achievement gap with other Bromley pupils. An increasing proportion of young people who start Year 12 in education remain in education, reflecting the early identification of young people who are at risk of becoming NEET (not in education, employment or training). However, in this academic year the proportion of young people dropping out in Year 12 has increased. The virtual school currently lacks capacity in the team to support this cohort. (Recommendation)

73. Procedures for monitoring children and young people who are missing from care are ineffective. Of 287 children looked after, 11% (32) children had at least one 'missing' episode in the past 12 months. Overall, there were 184 'missing' episodes. Only 13 children were offered 'return' interviews with an independent provider. This means that risks to children and young people are not well understood. Information is not gathered either to inform prevention and support plans for individual children or to inform wider strategic planning in relation to specific risks, such as sexual exploitation and child trafficking. (Recommendation)

74. The current Living in Care Council (LinCC) is comprised of a group of children and young people of differing ages, ethnic backgrounds, genders and abilities. This cross-section of Bromley's children looked after population ensures that the views of a diverse range of children and young people help to shape children's services. Children and young people have regular meetings with key senior managers of children's social care, elected members and executives of the working party for safeguarding and corporate parenting to help to influence service development, policy and practice. They undertake practical tasks to enhance the positive experiences

of children looked after, including developing the LinCC website, and the design and production of a welcome pack for children newly looked after. Dedicated participation and engagement workers ensure that information is communicated to children looked after through their carers and social workers. This includes information about keeping safe online and support in relation to bullying.

The graded judgement for adoption performance is that it is inadequate

75. Children who are unable to return to their birth parents are not always considered for adoption, and too many are not considered soon enough. This means that too few children are adopted and, for those that are, the process takes too long.

76. Only 10% of children leave care in Bromley through adoption, which is considerably below the England average of 16%. The current three-year average time in Bromley for children to be placed with their adoptive parents after entering care is 686 days. This shows a worsening performance compared to the published 2012–15 average, which was 659 days, and is 66 days slower than the England average for the same period.

77. The three-year average time for children to be matched with adopters, following the granting of a placement order, is 252 days for 2012–15. While there has been a small recent improvement in this measure, the three-year average is worsening and currently stands at 260 days. This is considerably slower than the Department for Education threshold of 121 days.

78. In Bromley, the reasons for this poor performance are not well understood by managers. Performance is deteriorating. Managers suggest that the reduction in the number of children adopted is due to an increase in special guardianship orders being granted. However, there have been fewer this year (12) than last year (23). This belief has inhibited scrutiny and systematic exploration of the data. Although welcomed, the recent work by the local authority concentrated entirely on the characteristics of the children waiting to be adopted rather than the reasons behind the delay. (Recommendation)

79. The delay experienced by children is characterised by overoptimistic assessments of birth parents and families. This means that many children are not considered for adoption or other permanence options soon enough. Managers and IROs are not effectively challenging the delay. Inspectors reviewed cases where even very young children had come into care, yet adoption had not been considered at the earliest opportunity.

80. The local authority lacks the confidence and ability to evidence effectively to court when adoption is the preferred plan. Inspectors considered cases where a plan for adoption had been changed or was not considered while

assessments of wider family members were undertaken, even when these were not likely to lead to a successful placement. A multi-agency working group, involving managers from the local authority, representatives from the court and Cafcass, has been ineffective in addressing this issue. Cases evidenced parents being given multiple opportunities to demonstrate their parenting ability before decisive action was taken, resulting in some children remaining uncertain about their futures for too long. For adopted children, this means that they do not settle into their 'forever' families until they are older.

81. In the vast majority of cases, children remain with the same foster carers after entering care until they move in with their adoptive families. The local authority has only very recently started to consider fostering-to-adopt, and only one child has been placed in a fostering-to-adopt placement via agency adopters.

82. Once a plan for adoption is confirmed, family finding is thorough, detailed and sensitive to the needs of the child. However, too few children reach this stage. In a small number of cases, there is delay as a result of social workers spending too long identifying an ethnic match, rather than concentrating on a search for parents who could best meet the needs of the child.

83. There are more approved adopters waiting for a child than children waiting to be adopted, meaning that Bromley adopters can consider children from outside the borough. This does not inhibit family finding, and inspectors saw evidence of considerable efforts to achieve the right match for the child.

84. Adopter assessments are thorough, but they often take too long to complete and performance on this measure is worsening. Initial contact to the assessment commencing currently takes 136 days, compared to 82 days nationally. The duration of assessment is currently 272 days, up from 260 days last year and above the national average of 231 days.

85. Prospective adopter reports (PARs) considered by inspectors were all of an adequate standard. Strengths and vulnerabilities are appropriately identified, although the quality of the analysis could more effectively reflect prospective adopters' ability to overcome their vulnerabilities. Adopters spoken to were positive about their reception and assessment by Bromley, and considered that they had been very well prepared for the experience of parenting an adoptive child. Child permanence reports (CPRs) detail the family history and give a clear picture of the child. However, in some cases, better analysis of how the trauma experienced by children might affect them into adult life would better inform the assessment for post-adoption support services. Where brothers and sisters have a plan for adoption, there is evidence of appropriate 'together or apart' assessments.

86. Once family finding begins, children and families are thoughtfully matched and there have been no placement breakdowns pre- or post-order for more

than two years. Matching reports comprehensively consider why parents have been chosen to adopt the child, and how their skills and experiences will enable the child to flourish. Adopters are offered the opportunity to meet with a range of professionals involved in the child's life in order to build a clear picture of what the child is like. The medical adviser speaks to parents about the implications of any health issues in caring for the child, ensuring that parents are well prepared and able to make realistic decisions about their ability to offer a home to a child.

87. Introductions are managed well. Children are appropriately prepared for moving in with their adoptive parents. Experienced foster carers know the children well, and advise and support adopters during the transition period. In many cases, they have continued to maintain contact after the child has moved. This means that children who are adopted are helped in the early stages to develop safe and secure attachments to their new parents. A dedicated post-adoptive support team offers support to all families with adoptive children who live in Bromley, assessing and addressing any difficulties that the family may experience. Staff have a range of skills including family therapy, 'theraplay' and safebase training. This team also offers support in maintaining contact between brothers and sisters, as well as support to birth parents. Currently, 22 birth parents are receiving counselling through the service. Inspectors saw some effective arrangements to ensure that contact with family members was maintained, including where brothers and sisters had been adopted by different families.

88. Life-story books seen during the inspection lacked some critical information and are not always completed in a timely way. In some cases, considerable delays mean that children do not have access to information that will help them to understand their histories. Later-life letters are generally thoughtfully crafted, and they provide a detailed and honest exploration of the child's early life and how they came to be living with adoptive parents.

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

89. There is an insufficient range of safe and suitable housing available for care leavers. The local authority regularly places a significant number of care leavers in bed and breakfast accommodation, and has done so for several years. Managers do not consider the risks that other residents may pose to young people or assure themselves of the safety of care leavers placed in bed and breakfast accommodation. During the inspection, two female care leavers were moved to new accommodation following a disclosure that the landlord had made inappropriate comments via text.

90. Too many young people stay in bed and breakfast accommodation unnecessarily and for too long. At the time of the inspection, over a third of the 16 young people in bed and breakfast accommodation, all aged 18 years old or over, had been in this type of accommodation for more than six months. Young people placed in these settings are frequently the most vulnerable, live chaotic lifestyles and have exhausted all other housing options available to them. Often, they do not engage well with the leaving care team or other support that is available, placing themselves at unacceptable risk and significantly decreasing their chances of securing good outcomes for their futures.

91. Social workers and young people's advisers find it difficult to maintain regular and meaningful contact with young people who repeatedly move in and out of temporary accommodation. Young people find it difficult to settle in one place, obtain the help that they need to move forward in their lives, manage their health, and achieve their educational and career goals. However, the local authority is successful in promoting foster care as an option for young people beyond their 18th birthday. In the last year, all those in foster care placements who turned 18 years remained in stable placements with their foster carers. Local authority staff fail to engage effectively with more challenging young people. While young people's advisers and social workers know of young people's needs, they struggle to engage a significant minority of young people who have more challenging behaviour or are reluctant to take up offers of help. Managers do not intervene quickly enough when outcomes for young people are not improving or when young people do not engage.

92. In most cases considered by inspectors, young people had an up-to-date pathway plan. However, plans are too often insufficiently detailed regarding the specific steps to be taken for young people to achieve their goals. Too many plans are reliant on vague initial actions and, too often, there is no effective contingency plan on what to do if this first step proves unsuccessful. As a result, some more vulnerable care leavers do not engage with the leaving care team or support services for long. In these cases, social workers, young people's advisers and managers do not know enough about young people's circumstances to be able to plan their next steps. For those aged over 18 years, the offer of help to them is considered sufficient, regardless of whether young people take up this offer. (Recommendation)

93. When young people do engage, the majority have good support from social workers and young people's advisers. They make good progress and take increasing responsibility for themselves. Staff act as effective advocates for young people with other agencies to ensure that they receive their benefits and entitlements. However, some care leavers who are in settled accommodation say that infrequent contact with their advisers leads to them feeling isolated and lonely. When young people receive support from a mentor, this helps to alleviate these feelings.

94. A specialist adviser supports young people into education, employment and training (EET), which is a comparable number to care leavers in similar areas. Inspectors saw good examples where work experience builds young people's readiness for work and leads to permanent employment opportunities. However, almost a third of care leavers aged 19 years are not engaged in education, employment or training (NEET), and this has been the case for the last three years. The proportion of care leavers who move into higher education is slightly lower than those in similar areas, despite appropriate financial support being available to them.

95. Inspectors saw some examples where young people's advisers provided some useful support to care leavers in helping them to prepare for living independently and managing their own affairs. An example is through providing practical help with budgeting and developing plans to repay rent arrears. A 'moving on' workshop is available to care leavers to help them to understand their responsibilities when they secure their own tenancies. However, some felt that the workshop took place too far in advance of them living independently, and they had forgotten what they had learned by the time they had moved in. There is a sufficient range of funding available to support care leavers as they move towards independence. For example, funding is provided for essential books for those in further education, clothing grants are made and young people receive a £2,500 allowance when they obtain their first tenancy. Young people said that they are aware of their entitlements, but told inspectors that not having access to the full 'setting up home' allowance prior to moving in meant that their first home was not fully equipped when they took up their tenancies.

96. All care leavers are offered a face-to-face meeting with the looked after children's nurse before leaving care to receive their health history, recorded on a health passport. However, only around half of the young people spoken to by inspectors were aware of their health history, and none knew about the health passport. The appointment of a dedicated nurse is intended to develop new ways of sharing health information with care leavers and to ensure that they have access to information to help them to manage their own health as they become more independent.

Leadership, management and governance	Inadequate

Since the inspections by Ofsted in 2010 and 2012, failures of senior leadership and weak management have resulted in a deterioration of services for children's safeguarding, children looked after, care leavers and children requiring adoption. Elected members, the chief executive and senior leaders across the local authority do not have a good enough understanding of the strengths and weaknesses of their services for vulnerable children in need and those requiring protection. They were unaware of the extensive deficits identified in this inspection.

Political leaders and chief officers state that vulnerable children are a top priority for the council. This is not evident corporately or in service provision. While the senior leadership of the council, the corporate parenting group and partner agencies express high ambitions for children and young people in their care and those leaving care, the services for these children and young people are inadequate.

The interim DCS and her senior management team have continually absorbed additional responsibilities in response to the local authority's financial pressures. This has led to reduced capacity across all areas of service, contributing to the lack of managerial scrutiny and the identification of poor practice.

Weak management oversight of cases at all levels, including by senior managers, is ineffective and not systematic. Performance management information is insufficiently used to improve practice. There is an absence of critical enquiry. Quality assurance arrangements are inadequate, and case auditing does not demonstrate rigour in scrutinising the quality of work. Supervision does not consistently take place in accordance with the local authority's own stated policy.

Strategic managers do not routinely assess risks to those at risk of sexual exploitation, and to children and young people who go missing.

The implementation of the current social work model is beginning to have an impact in identifying risk in the MASH, and in the quality of some children's assessments in both the referral and assessment, and the safeguarding teams. Staff report that this model is helping to bring clarity to their work.

The local authority and partner agencies work well together to provide good, early, targeted support in children centres. The integrated troubled families project (Bromley children's project) is helping many families with entrenched difficulties to improve their care and parenting.

The workforce development strategy is effective in attracting and supporting newly qualified social workers.

Inspection findings

97. The lead member, the chief executive and the interim director of children's services (DCS) do not have a clear understanding of the strengths and weaknesses of children's services. They were unaware of the significant deficits identified in this inspection. These included inconsistent responses to identifying child protection risks, drift and delay in progressing work for children looked after, poor management oversight and inadequate quality assurances processes. Throughout the inspection, in response to these failings, managers have taken action, demonstrating a commitment to addressing such weaknesses. An example is the immediate changes to ensure compliance with child protection procedures, and the devising of an action plan to address concerns about the inconsistent quality of practice for sexually exploited and missing children.

98. While there are clear lines of accountability and governance arrangements between political, strategic and operational roles, this is not framed within a shared strategic plan. Services for vulnerable children and their families are given insufficient priority across the local authority. Senior officers, corporately, do not work collaboratively enough to ensure that the needs of Bromley's vulnerable children are championed. Elected members engage with the children's agenda and are active participants on the Bromley Safeguarding Children Board, Safer Bromley Partnership, Corporate Parenting, and Health and Wellbeing Boards. However, this is not leading to effective collaboration or service improvement. Proposals by members to address financial pressures lack sufficient analysis and understanding of the underlying complexities and impact on children's services, including the risks. This inhibits the effectiveness of those with lead responsibility for children's social care in improving outcomes and sustaining longer-term change.

99. With the departure of the previous DCS in April 2015, interim arrangements were made to delegate the statutory functions to the assistant directors (ADs) for children and education services, supported by the chief executive. The AD for children is the named statutory interim DCS. However, she has limited authority corporately to lead, share or drive forward change. These interim arrangements have continued for too long. At the same time, the DCS and her senior management team have absorbed extensive additional responsibilities as part of the council's financial pressures. This has reduced capacity across all areas of service, contributing to poor managerial scrutiny and management failures. (Recommendation)

100. Management oversight of cases, including scrutiny by senior managers, is ineffective. As a result, managers do not routinely monitor and assess progress and risk to all children. Social work caseloads in the referral and assessment, and safeguarding teams are too high and do not create an environment where social workers can do their job properly. Practice is not consistently robust and, in too many cases, assessments and plans are not of

a good enough quality, leading to significant drift in progressing work. (Recommendation)

101. Available performance management information is used insufficiently to drive practice. There is a lack of critical enquiry by senior managers and leaders, and a failure to interrogate data. For example, there is no data on children in need, the largest cohort of children receiving the support of children's services. Quality assurance arrangements are inadequate, as case auditing does not demonstrate rigour in the work carried out. Escalation processes are not routinely utilised by IROs or conference chairs to alert senior managers to the impact of the significant deficits in practice that are identified in this inspection. (Recommendation)

102. The quality and frequency of formal case and professional supervision are not of a consistently adequate standard. There are some examples of supervision records utilising the local authority social work model, but the large majority did not meet this standard. The supervision template is very clear about what is to be achieved, but too few actions identified in previous supervisions are reviewed. The better supervision records give clear management direction, with timescales and rationale for decisions. However, many records lack evidence of reflective practice and challenge. Actions are not tracked between sessions, leading to drift in progressing plans for too many children.

103. Placement stability for children looked after in foster care is strong, with a high proportion living in family placements. At the time of inspection, proposals by elected members to change the level of support to foster care was causing considerable fragility in the system. Foster carers told inspectors that they did not feel valued. The importance of ensuring that there are sufficient local placements for children is a stated priority for the local authority. The lead member for children and leader of the council gave assurances to inspectors that children's placements would not be destabilised or children left at risk.

104. The corporate parenting strategy group, chaired by the interim DCS, and the member-led corporate parent executive working group have had success in improving health and educational outcomes for children looked after. However, overall the pace of change has been too slow in fundamental areas for too many children in care and care leavers. For example, in 2015 a task and finish group was established to prevent homelessness and reduce the number of care leavers in unsuitable accommodation. At the time of the inspection, inspectors found that senior leaders were aware of the routine practice of placing vulnerable care leavers in bed and breakfast accommodation for extended periods. This is not acceptable. Inspectors found that services for children looked after, care leavers and those requiring adoption are inadequate.

105. Strategic arrangements for understanding, analysing and evaluating outcomes for children at risk of sexual exploitation are underdeveloped. Prior to the inspection, the local authority in partnership with police colleagues revised the function of the multi-agency sexual exploitation (MASE) group. They recognise that work is required to assess the profile of perpetrators and victims, and to understand the circumstances and environments that make children and young people more vulnerable to sexual exploitation. Plans to disband the monthly multi-agency case-focused planning meeting were withdrawn when inspectors raised concerns about the need to have a holistic response that links children across agencies. (Recommendation)

106. Missing children procedures and protocols are not routinely followed. Instead, there is a piecemeal approach. Too many children in care are not being offered a return home interview. In cases seen of children missing from home, the quality of the return home interviews by the teenage and patenting support service (TAPSS) is good, with a holistic approach to understanding family pressures and provision of effective intervention following 'missing' episodes. Inspectors were advised that this team was being disbanded to find financial savings. Currently, there is no corporate system for aggregating or cross-referencing information from return home interviews with those children at risk of, or being, sexually exploited or involved in gang activity.

107. Safeguarding and children looked after information is included in the joint strategic needs assessment (JSNA). For example, there is comprehensive analysis on the emotional and educational needs and outcomes for children looked after. The JSNA highlights that health measures tend to be of processes (for example, the number of health checks or dental checks), rather than qualitative information on actual levels of health. There are significant gaps in the JSNA for some groups of vulnerable children, for example the high number of children known to early help services and children's social care as a result of parental domestic abuse, mental health and substance misuse. There is no reference to child sexual exploitation or those missing from home or care. Consequently, this limits senior leaders' understanding of prevalence, and impacts on local priority decisions by leaders and their evaluation of whether resources could be commissioned to ameliorate such issues.

108. The chair of Bromley's Health and Wellbeing Board (HWB) acknowledged that it is still learning how to utilise the JSNA to best effect. Key priorities of the HWB strategy include promoting the emotional well-being of children and countering childhood obesity. The board's agenda is both demanding and predominantly adult focused. The LSCB chair is a member, and ensures that the safeguarding of vulnerable adults and children is discussed. The interface with senior officers in children's services is less apparent. However, holding combined meetings with adult, children and health committees is reducing 'silo working', and has been effective in improving the health and educational

outcomes of children looked after. There is little evidence that safeguarding is a key focus for the HWB.

109. Bromley commissions an extensive range of early help and statutory services for children. A number of senior managers corporately share responsibility, leading to a lack of cohesion in approach, conflicting priorities and the fragmented evaluation of services. The local authority has successfully reviewed and recommissioned a single, targeted service for children with emotional and mental health problems. There is evidence of effective work with the clinical commissioning group, for example in jointly commissioning residential services for disabled children. However, the DCS accepts that more work is required if children and their families in Bromley are to benefit from a carefully planned, dedicated and child-centred commissioning strategy. (Recommendation)

110. The workforce strategy is comprehensive and ambitious. The local authority has invested in access to good-quality training. This is reducing attrition among qualified social work staff. There is a comprehensive and well-established training programme for 15 newly qualified social workers. This is linked to local universities and is moderated independently, in partnership with other local authorities. The implementation of the current social work model is beginning to have an impact on identifying risks, and staff report that this model is helping to bring clarity to their work. There is an effective strategy to develop the skills and knowledge of senior practitioners. However, the local authority recognises that its workforce strategy also needs to focus on the development of its middle and senior managers.

111. Complaints are managed well by a designated complaints manager. Heads of service and team managers receive a weekly update on all active complaints. Learning from complaints is cascaded to managers and elected members on a quarterly basis. There was an increase in complaints to children's social care, with 73 formal complaints in 2015–16 compared to 55 in 2014–15. These relate mainly to children's cases before the courts. Commissioned independent advocates support children, resulting in most complaints made by children being resolved informally.

112. Bromley proactively delivers in line with the Prevent duty, raising awareness in schools and successfully intervening to prevent the escalation of concerns. For example, recent cases demonstrate excellent multi-agency work when the local authority was proactive in taking the matter to court, successfully securing wardships for three children. The counter-terrorism unit expressed considerable appreciation of the local authority's open and professional approach to this complex work.

113. The judiciary expressed significant concern about the quality of the children's services' legal representation in court. The local authority does not instruct sufficiently experienced lawyers in complex cases. Representations have been made by the judge to the local authority on a number of occasions,

with little impact or improvement. Evidence is not prepared well. There is a lack of understanding about what constitutes good evidence. Consequently, the PLO is implemented neither effectively nor quickly enough. Senior managers do not have a system to assure the quality and timeliness of decisions. This results in drift and delay in children achieving legal permanence.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement

Executive summary

The Local Safeguarding Children Board (LSCB) in Bromley requires improvement to be good. Bromley's LSCB complies with its statutory responsibilities and the requirements of 'Working together 2015'. The chair of the board and its members work closely together. Since the chair was appointed in April 2015, there have been a number of improvements to board organisation and a greater focus on safeguarding priorities. However, the board needs to develop a more critical overview of practice and performance to understand fully the quality of practice in safeguarding services, and the experiences of children and young people in Bromley.

The LSCB's understanding of the extent and prevalence of child sexual exploitation and associated risks, particularly when young people go missing, is compromised by poor data and poor qualitative information on practice.

There is insufficient overview by the LSCB of the introduction and effectiveness of the local authority social work model of risk assessment. This is a key area of practice improvement in Bromley, and the board needs to ensure that it has oversight of its implementation, its impact on assessing need and the service response to minimising risk to children.

The LSCB's engagement with young people needs focus, and the board has not yet ensured that it hears the opinions of young people clearly and in a systematic way. This presents as a missed opportunity to understand and respond to their needs.

A comprehensive multi-agency training programme ensures that a wide range of staff benefit from key training in safeguarding issues. The programme is evaluated for effectiveness, and it responds to the development needs of staff.

A multi-agency auditing programme looks at areas such as neglect and domestic violence, as well as ensuring, through its S11 agency audit, that safeguarding procedures are in place in all agencies working with children in Bromley. The board conducts serious case reviews and case management reviews to identify issues. It ensures that these are published and lessons learned.

The LSCB is active in ensuring that policies and procedures are in place, and that it influences the development of practice. These procedures include on the issue of female genital mutilation, ensuring that there is a child sexual abuse strategy in place, and that children and families receive early help through the effective operation of Bromley's early intervention model.

Recommendations

114. The LSCB should establish a performance dataset that ensures that it can measure progress against its key priorities.

115. The LSCB should ensure that there is critical enquiry and challenge in relation to the core safeguarding activity undertaken by all agencies.

116. The LSCB should actively seek the views and opinions of children and young people, and engage them in a systematic manner in order to ensure that it is aware of and benefits from their experiences.

117. The LSCB should ensure that multi-agency arrangements for the oversight of children missing and at risk of sexual exploitation are underpinned by effective information sharing, performance monitoring and action planning, and are strategically coordinated and monitored by the board.

118. The LSCB should ensure that the arrangements for children privately fostered comply with statutory guidance, and that they are safe and that their health and well-being are properly promoted.

Inspection findings – the Local Safeguarding Children Board

119. Bromley Safeguarding Children Board complies with its statutory responsibilities as defined in 'Working together 2015'. It is appropriately constituted and includes two lay members. Since the appointment of a new chair in April 2015, the LSCB has been restructured and has reorganised its sub-groups to focus more closely on priority areas such as vulnerable children, and the development of policy and procedures. Although a relatively recent development (autumn 2015), only one sub-group (training) is now chaired by a social care manager, with others being chaired by senior members of partnership agencies, including education and health. This strengthens the collaborative commitment of all partners. LSCB members consider that they work well together and that the creation of a leadership group of sub-group chairs in autumn 2015 gave clear direction to the work of the board. The chair acknowledges that the changes made reflect a need for a greater level of practice focus and critical enquiry. (Recommendation)

120. The LSCB's business plan for 2015–18 identifies five key priority areas, together with appropriate performance measures, including milestones and rating of progress. However, it does not identify the implementation of the current social work model across Bromley as a key measure to improving the identification and minimisation of risk, and as an area that the LSCB should monitor for effectiveness. This means that the board does not have sufficient focus on a key area of practice that was introduced to make a difference to children in Bromley.

121. Governance arrangements are not all yet in place to ensure that partners, such as the Health and Wellbeing Board (HWB) and the Children's Board, are fulfilling their responsibilities to help, protect and care for children and young people. A written partnership agreement has recently been proposed between the LSCB and the HWB, setting out the nature of their relationship and mutual expectations. However, the LSCB has kept the HWB aware of issues, including raising self-harm and homelessness as topics for the HWB to consider in their current review of partnership strategy. The chair of the LSCB does not attend the Children's Board and this is a gap, given that this group has a focus on outcomes for children at risk in the community. This means that the LSCB is not as influential as it should be in scrutinising and challenging safeguarding activity.

122. The chair of the LSCB meets on a regular basis with the chief executive and the DCS. The director of adult services also attends, in recognition of the chair of the LSCB's additional role as chair of Bromley's adult safeguarding board. This provides continuity across both safeguarding agendas. The chair meets with elected members at board meetings and separately.

123. The board is provided with a dataset from individual agencies, including the police, health and social care. However, the information provided has not yet been tailored to the board's needs and omits key information, particularly in relation to child sexual exploitation. There is no reporting of the total number of young people missing, apart from those in care and those missing education, and no data on the timeliness of 'return' interviews or the prevalence of domestic abuse. This means that the board cannot have a clear picture of all relevant safeguarding activity. While some of these gaps have been filled by other means, for example a recent report on missing young people looked after provided to the vulnerable children sub-group, the LSCB does not yet have a sufficiently focused set of performance data to rely upon. (Recommendation)

124. The LSCB has a comprehensive multi-agency training programme. It ran 18 courses in 2014–15, with 535 people attending and a further 1,955 undertaking a variety of e-learning modules. There is an established evaluative process, including post-course evaluation three months after the event, and all training sub-group members observe training courses to assess the quality of content and delivery. Feedback from learning is used to inform future commissioning of training, together with an analysis of need undertaken by the training sub-group. However, the annual training evaluation report could be more informative in relation to the effectiveness of courses, better to inform the board of the experiences of staff.

125. The LSCB undertakes regular monitoring of frontline activity. It has a multi-agency audit programme, which considered reducing the risk of child sexual exploitation, the response to MASH contacts and practice on domestic abuse. An audit in relation to practice on neglect in 2014 has an ongoing action plan, last updated in January 2016. As a result, the LSCB has been able to

produce a detailed improvement action plan based on audit outcomes, and has a comprehensive overview of progress. A 2016–17 multi-agency audit programme proposes a focus on the effectiveness of core groups and a review of MASH effectiveness. However, it has not yet agreed how this activity is to be funded to ensure that there is an appropriate level of independence, and the board has identified this as an ongoing risk to the auditing programme.

126. The LSCB has undertaken a range of activity to ensure that it both influences and understands child sexual exploitation in Bromley. A review undertaken at the end of 2014, supported by a further multi-agency audit in January 2015, assessed whether risk had been reduced in child sexual exploitation cases. The policy and procedures sub-group is currently ratifying an updated protocol to counter child sexual exploitation. The LSCB also receives information on disruption activity and cases that are considered at the multi-agency sexual exploitation (MASE) panel. However, the understanding of the extent and prevalence of child sexual exploitation and associated risks, particularly of young people who go missing, is compromised by poor data and poor qualitative information on practice. To date, the LSCB has not demonstrated sufficient critical enquiry in these areas to ensure that it has a robust overview of risk and practice.

127. A programme of section 11 audits on a two-yearly basis is overseen effectively by the LSCB, with agency returns considered at a section 11 review panel. The current 2014–16 audit cycle is now complete, with only one instance of agency non-compliance. The LSCB can evidence challenge when audits have not met an appropriate standard through an action log, updated at six-monthly intervals. This log is an effective measure of progress and implementation. The LSCB has also sought to ensure that schools complete section 175 audits, with a current completion rate of 63%. There is recognition that some schools lack an understanding of the purpose of either the audit or the function of the LSCB. On such occasions, the board has sought to engage with them, on an individual level, to ensure compliance.

128. The LSCB has a local learning and improvement framework for statutory partners, which sets out how it will monitor and review practice, and learn lessons. It conducted and published a serious case review (SCR) regarding Child E in February 2015 and oversaw a subsequent action plan monitoring the progress of actions identified across the partnership. There has been dissemination of lessons learned through single-agency briefings, a joint social care and health seminar, and four multi-agency briefings. The LSCB conducts multi-agency reviews of cases which do not meet the threshold for a serious case review yet where there are safeguarding concerns. Wider learning from SCRs is included in the LSCB training offered across a range of courses, including those concerning domestic abuse and neglect.

129. The child death overview panel (CDOP) produces an annual report on activity and a comprehensive analysis identifies trends. It is active in promoting

issues to improve awareness, including the dangers of co-sleeping and encouraging resilience among young people to prevent self-harm.

130. The LSCB is active in ensuring that policies and procedures influence the consistency and quality of practice. In December 2015, the threshold document 'The child's journey in Bromley' was revised, setting out threshold criteria, referral pathways, and the role of early intervention and the use of the CAF. The LSCB receives regular updates on numbers of CAFs and trends. This supports a partnership understanding of the framework and the importance of early joint working. Together with the Bromley adult safeguarding board, the LSCB has also recently agreed and published a multi-agency intervention framework for identifying, assessing and responding to female genital mutilation. It has also put in place and updated a protocol for escalating concerns and resolving professional differences. The LSCB's domestic abuse audit has been influential in ensuring that domestic abuse is a priority in the 2016–18 community safety plan.

131. A challenge log has recently been implemented formally to evidence challenge in relation to practice, including the timeliness of initial health assessments for children looked after, lack of engagement by some schools in completing section 175 returns, and the use of missing and return home interviews. Evidence of challenge is not always well recorded in LSCB meeting minutes, or in sufficient depth in relation to practice.

132. The LSCB does not have a plan to engage with young people and has not met with members of the Bromley Living in Care Council (LinCC). The LSCB has not yet ensured that it hears the opinions of young people clearly and in a systematic way. There is recognition that this is a gap, and the chair has ensured that meetings are held in venues such as schools. This offers an opportunity to meet with young people. A more planned approach is needed to ensure that the LSCB is informed of young people's views and that they are offered an opportunity to contribute to the board's work. (Recommendation)

133. The board publishes a detailed report annually. It considers a wide range of LSCB activity, including the work of its sub-groups. It identifies and reflects on the outcomes of multi-agency audits, including areas for development. The report appropriately identifies business plan priorities, but could better identify progress against these in order to offer a measure of its performance. The LSCB does not sufficiently monitor the arrangements for children and young people who are privately fostered. (Recommendation)

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

The inspection team

Lead inspector: Marcie Taylor

Deputy lead inspector: Brenda McLaughlin

Team inspectors: Karen Wareing, Tracey Metcalfe, Anji Parker, Jon Bowman, Peter McEntee

Shadow inspectors: Alison Smale, Sandra Jacobs-Walls

Senior data analyst: Judith Swindell

Quality assurance manager: Sean Tarpey

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Store Street
Manchester
M1 2WD
T: 0300 123 4234
Textphone: 0161 618 8524
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