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20 September 2017

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Dear Annie

Monitoring visit to London Borough of Lambeth children's services

This letter summarises the findings of the monitoring visit to Lambeth children's services on 22 and 23 August 2017. This was the seventh visit since the local authority was judged inadequate in February 2015. The inspectors were Brenda McLaughlin HMI, Louise Hocking HMI and John Roughton HMI.

The director of children's services (DCS) continues to show strong and tenacious leadership that is having a positive impact on most services for vulnerable children in Lambeth. As well as a clear vision, she holds an accurate picture of the service that she leads. Many of the essential components are in place to ensure further progress, but the quality of practice remains too variable. A comprehensive, updated self-assessment identified many of the deficits seen during this visit. However, these elements of good leadership and governance have not yet secured consistently good enough social work practice and frontline management. Inspectors found serious concerns in some cases in the multi-agency safeguarding hub (MASH) and in the child assessment teams (CATs) that were having an impact on children and families. Inconsistent management oversight and supervision were common features in too many cases. Children looked after receive better services but the work is not consistently good. In the cases sampled and tracked, a number of children were referred to senior managers because of ineffective operational practice to help and protect neglected children, those experiencing abuse, young people at risk of sexual exploitation and those missing from home or care.

Areas covered by the visit

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

- the quality of management oversight and challenge within the MASH to improve decision-making and the provision of help to children and young people
- the effectiveness of management oversight and quality assurance systems in the CATs to help and protect children
- the quality of practice and planning for children looked after.

A range of evidence was considered during the visit, including electronic case records and supervision notes. We reviewed the local authority self-assessment and performance information, and commented on the quality and impact of audit activity and the effectiveness of management oversight. In addition, we spoke to a range of staff, including managers, assistant directors and social workers.

Overview

Information from a range of areas, including performance data, practice weeks, audits and sampled and tracked cases, as well as recent action to strengthen partnership working in the MASH, indicates some improvement in social work practice. However, inspectors and senior leaders remain concerned that risks to children are not being managed consistently. This visit found that social work practice in the MASH and in the CATs to help and protect children is not rigorous enough; the focus on improving timeliness is having a positive impact, but the quality of work is still inconsistent. As a result, social workers miss opportunities to understand children's lived experiences. In the cases seen by inspectors, CAT workers had often seen children on only one occasion, leading to superficial assessments that fail to fully address risk and needs. In better cases, children benefit from timely and well-considered risk assessments, helping and protecting them from harm. Services for children looked after or children who need to be adopted, while improving, are not yet good enough.

Findings and evaluation of progress

On 1 August 2017, Lambeth introduced the integrated referral hub (IRH), which brings together the 'first response' social work service and early help staff. The IRH is intended to ensure that children receive the right level of help and protection quickly. Inspectors found a lack of professional curiosity and a lack of rigour shown by some staff and managers in the IRH, leading to unsafe decisions for some children. The introduction of daily MASH and early help hub meetings has reinvigorated much-needed multi-agency engagement to support vulnerable children, although it is too soon to evaluate the impact. However, there is evidence that the early help manager and the experienced early help coordinator are working together effectively to ensure that thresholds are better understood by partners, and are consistently applied and reviewed. For example, of the 32 cases reviewed since July 2017, seven were re-referred to children's social care, as the thresholds had not been applied correctly.

In March 2016, there were 297 children on a child protection plan in Lambeth. This fell to 138 by May 2017. Senior local authority leaders worked together with members of the Local Safeguarding Children Board to try to understand this decline. They found that section 47 enquiries had not been carried out for a number of children who had experienced significant harm because of physical abuse or who were at risk from parental domestic abuse. Initial child protection conferences have now taken place for some children following this review. At the time of the visit, the number of children on child protection plans had risen to 163. Urgent work is currently being undertaken to ensure that managers and staff recognise risk and that assessments consistently lead to timely child-centred planning and decisions that make children safer.

Children in need of help and protection are transferred promptly to the CATs. Management direction at the point of allocation is clear and appropriate in most cases sampled and tracked. Initial direct work to ascertain the views of children is regularly undertaken using age-appropriate tools, but follow-up visits to get to know children better or to understand their experiences rarely take place. This leads to superficial assessments. Inspectors found too much delay; for example, three children from one family, who became subject to child protection plans in July, had not been visited at the point of the inspection. In better cases, risks are analysed and responded to quickly, assessments are child-focused and children are seen on their own. In all cases seen (19 sampled and six tracked) in the CATs, there is little evidence of effective management oversight following initial allocation.

In a small number of section 47 enquiries undertaken, appropriate decisions were taken to ensure that a child would not be able to return home overnight. However, in those cases in which the children did return home, there was no evidence of a risk assessment or management agreement that it was safe for them to do so. Written agreements used in these cases were not overseen or signed off by managers. In other work, the local authority failed to respond to the needs and risks facing individual children in larger families. In a small number of cases referred to the DCS, managers did not demonstrate that they understood their statutory duties to assess and protect children.

In contrast, services for children looked after in Lambeth continue to improve, albeit from a low base. All cases seen by inspectors were at least adequate. The children looked after service manager practises and expects effective child-centred social work, and this approach is highly valued by frontline staff. Successful staff recruitment and manageable caseloads have led to 32 out of 36 social workers with an appropriate skill mix now being permanent. Children looked after benefit from stable placements and committed foster carers. Good examples of practice include achieving permanent homes for children who cannot live with their families, working with adolescents with complex and changing needs and carefully evaluating and escalating risks. Life story work and direct work are becoming more evident.

However, practice remains variable, with some case files showing gaps in management oversight and records of supervision. The take-up of return home interviews remains low, although individual social workers have a better understanding of 'missing' than the data or records show. Social workers do not yet confidently exercise their individual judgements, for example in visiting more than the minimum requirement when needed, in making each visit purposeful for the child or using a broad range of strategies to engage with resistant children. Care plans are completed but the emotional needs of children looked after and the impact of past experiences are not always sufficiently considered.

A robust workforce strategy is reducing a previously heavy reliance on agency workers, but a legacy of high turnover among social workers and managers, particularly in the CAT service, has had an impact on the quality of work to help and protect children. Staff told inspectors that they have good access to training and they are committed and positive about working for Lambeth. Performance information and quality assurance systems provide managers with a clear understanding of practice, and these inform ongoing priorities.

In summary, senior leaders know their services very well. They fully recognise that there is considerably more work to be undertaken to ensure that vulnerable children in Lambeth experience consistently good-quality help and protection from harm. There is a strong commitment and a relentless focus and determination to improve outcomes for children and their families.

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

Yours sincerely

Brenda McLaughlin

Her Majesty's Inspector