For General Release

REPORT TO:	**Cabinet 18 September 2017**
AGENDA ITEM:	**6**
SUBJECT:	**Ofsted Inspection of Children's Services**
LEAD OFFICER:	**Barbara Peacock, Executive Director, People Department**
CABINET MEMBER:	**Councillor Alisa Flemming, Cabinet Member for Children, Families and Learning**
WARDS:	**All**

CORPORATE PRIORITY/POLICY CONTEXT

Croydon Corporate Plan 2013-18

The recommendations address the following Corporate Plan 2015-18 priorities:

- To help families be healthy and resilient and able to maximise their life chances and independence
- To create a place where people feel safe and are safe

AMBITIOUS FOR CROYDON & WHY ARE WE DOING THIS:

The Independence and Liveability Strategies 2015-18 set out how the Council will achieve the commitments made in the administration's 'Ambitious for Croydon' election manifesto in respect of independence and liveability.

FINANCIAL IMPACT

£1m has been allocated from earmarked reserves to support the targeted improvement work over the remainder of this year. The impact on future years budget of the improvement work will be considered as the 2018/19 budget is agreed.

FORWARD PLAN KEY DECISION REFERENCE NO.

This is not a key executive decision.

1. RECOMMENDATIONS

The Cabinet is asked to:

1.1 Note the findings of the Ofsted Single Inspection Framework carried out between 20 June and 13 July 2017 as set out in Appendix 1.

1.2 Note the actions taken following the inspection.

1.3 Note the guidance from Ofsted in relation to local authorities that have received an overall judgement of inadequate as set out in Appendix 2.

1.4 Note the guidance from the Department for Education in relation to local authorities which have received an overall judgement of inadequate as set out in Appendix 3.

1.5 Note that a commissioner for Children's Services has been appointed by the DfE for an initial three-month period, and will report to the DfE on the progress on the improvement journey and the councils capacity and capability to take this work forward.

1.6 Delegate to the Executive Director of People in consultation with the Chief Executive and Lead Member for Children, Young People and Learning authorisation to develop and submit the improvement plan within the 70 day requirement for Ofsted.

1.7 Receive further reports on the council's response to the findings of the inspection and the action being taken to improve Children's Services in Croydon.

1.8 Note that the Scrutiny and Overview Committee, at its meeting on 5 September 2017, agreed to lead on scrutinising the progress of the overarching improvement plan and that each Children and Young People's Scrutiny Meeting will have a standing item to focus on a key theme in the Improvement Plan.

2. EXECUTIVE SUMMARY

2.1 Ofsted, the Office for Standards in Education, Children's Services and Skills, inspects and regulates services that care for children and young people, and services providing education and skills for learners of all ages.

2.2 Ofsted undertook a Single Inspection Framework (SIF) of the London Borough of Croydon's services for children in need of help and protection, children in need of help and care leavers during June and July, 2017. As part of this inspection there was also a review of the effectiveness of the Croydon Local Safeguarding Children Board (LSCB).

2.3 On 4th September 2017, Ofsted published its report providing an overall judgement that Children's Services in Croydon are inadequate. The Local Safeguarding Children Board was also judged inadequate, as inspectors found that the LSCB had not fully established effective arrangements to discharge its statutory functions. The council fully accepts the findings of the report.

2.4 Inspectors found a legacy of poor practice in the service. It was acknowledged that elected members and senior leaders were aware of the decline and the deficits in front-line practice. Action was taken, including the establishment of an improvement board and implementation of an improvement programme. While there have been some improvements and early impact, the council fully accepts the judgement and conclusions made in the inspection report, and that the overall level of performance and pace of change in children's services was not at the required level.

2.5 The council understands the seriousness and scale of the improvements needed and is committed to improving the lives of children and young people in Croydon and to increasing the pace of our improvements.

2.6 The council is committed to addressing the findings and recommendations in the inspection report and work has already started on making urgent improvements to the service before a final improvement plan is submitted to the Department for Education, which must be presented 70 working days (11th December) after the publication of the report.

2.7 This report outlines the outcomes of the inspection and details the key findings from the report, sets out the remedial action now being taken to address the most urgent and immediate concerns and the next steps in the overall improvement programme.

2.8 In addition, the report summarises guidance from Ofsted and the Department for Education in relation to local authorities that have received an overall judgement of inadequate. Ofsted will undertake a series of activities including an action planning visit, a programme of quarterly monitoring visits and a re-inspection once the period of monitoring has ended. The authority is also subject to intervention by the Department for Education (DfE) until services are improved.

3. INTRODUCTION

3.1 Ofsted has a statutory duty to regularly inspect each of the 152 local authorities' children's services. Although the council received a Joint Targeted Area Inspection (JTAI) in May 2016, the council's children's services had not been holistically evaluated with a published judgement since 2012, when services were found to the 'Adequate'.

3.2 Since November 2013, Ofsted has been assessing local authorities under the Single Inspection Framework (or 'SIF'). It is widely recognised that this framework is more rigorous than the previous inspection framework.

3.3 Since Ofsted introduced a new SIF in 2012, 142 local authority Children's Services have been inspected. Of these 34 have been judged inadequate, 64 require improvement, and 42 are good and 2 are outstanding.

3.4 The Ofsted inspection of services for children in need of help and protection, children looked after and care leavers (SIF) in Croydon, was carried out between 20th June and 13th July 2017. The inspection was undertaken over a period of four weeks by a team of 10 inspectors and consisted of data analysis, observation, case file audits, sampling, and interviews with members, senior managers, partner agencies and children and young people.

3.5 The SIF inspection reviewed the following:

- **The experiences and progress of children who need help and protection:** These are children and young people that;
  - are at risk of harm (but who have not yet reached the 'significant harm' threshold).
  - have been referred to the local authority, including those for whom urgent action has to be taken to protect them; those subject to further assessment; and those subject to child protection enquiries.
  - are the subject of a multi-agency child protection plan setting out the help that will be provided for them and their families to keep them safe and to promote their welfare.
  - have been assessed as no longer needing a child protection plan, but who may have continuing needs for help and support.
  - are receiving (or whose families are receiving) social work services where there are significant levels of concern about children's safety and welfare, but these have not reached the significant harm threshold or the threshold to become looked after.
  - are missing from education, or being offered alternative provision.

- **The experiences and progress of children looked after and achieving permanence:** These are children and young people looked after either by being accommodated under section 20 or those 'in care' during or as a result of proceedings under section 31 of the Children Act 1989 and those accommodated through the police powers of protection and emergency protection orders. This review also covered;
  - adoption performance
  - the experiences and progress of care leavers. These are young people aged 16 to 25 who are preparing to leave care, or who have left care.

- **Leadership, governance and management:** This review focused on the effectiveness of leaders and managers and the impact they have on the lives of children and young people and the quality of frontline practice.

  The review of the effectiveness of the Children's Safeguarding Board: This review evaluated the extent to which the CSCB complies with its statutory responsibilities in accordance with the Children Act 2004 and Working Together Regulations. It looked for evidence that it

coordinates the work of statutory partners in helping, protecting and caring for children in its local area and whether mechanisms in place to monitor the effectiveness of those local arrangements.

3.6 Inspectors make judgement on a four point scale;
- Outstanding
- Good
- Requires improvement
- Inadequate

4. OUTCOME OF THE INSPECTION

4.1 The overall judgement of the inspection is that children's social services in Croydon are inadequate. The overall effectiveness judgement is derived from performance in each of the key judgements. An inadequate grade in either the arrangements to help and protect or look after children and young people will always result in an overall effectiveness judgement of inadequate. In most cases it is also likely that if either the effectiveness of child protection or the effectiveness of provision for looked after children is inadequate, the leadership judgement is likely to be judged inadequate.

4.2 The grading for each part of the inspection areas are as follows:

1. Children who need help and protection	Inadequate
2. Children looked after and achieving permanence	Inadequate
2.1 Adoption performance	Requires Improvement
2.2 Experiences and progress of care leavers	Requires Improvement
3. Leadership, management and governance	Inadequate
4. Local Safeguarding Children Board	Inadequate

4.3 The council fully accepts the findings of the inspection and is committed to taking action to rectify the issues identified.

4.4 The Ofsted inspection report and review of the effectiveness of the Local Safeguarding Children Board is included at Appendix 1. The report goes into detail about the inspection findings in relation to each part of the SIF and includes 21 recommendations, the majority of which relate to improvements which are needed in front-line practice.

5. IMPROVING CHILDREN'S SOCIAL SERVICES IN CROYDON

5.1 The council fully accepts the need to improve and had begun to take proactive action ahead of the Ofsted inspection.

5.2 The legacy of poor practice identified by inspectors, had also been identified by elected members and action had been taken to address this. The new

leadership team, including the new Chief Executive and new Executive Director of People (who holds the statutory Director of Children's Services DCS function) were in in place from the end of July 2016. Following this, a number of external reviews were commissioned, an improvement board was established in January 2017, and an improvement plan was launched a month later in February 2017.

5.3 A new vision for children's services was developed by the Executive Director of People and lead member in consultation with staff and young people. This was launched in March 2017 and was presented to the council's cabinet. The vision underpins all our current plans and is focused on improving outcomes for children and young people

5.4 The improvement programme had begun to generate some improvements, which were recognised during the inspection, including a strengthening of the multi-agency safeguarding hub (MASH) and the use of performance information. However, we fully accept that the prioritisation and pace of change was not moving fast enough to support changes for individual children.

6. KEY INSPECTION FINDINGS

6.1 A summary of the key areas of improvement and areas of stronger practice across both the council and CSCB is included below.

Areas for improvement

- Widespread and serious failures in providing services for children and families that leave some children at risk of significant harm.
- Too many children are left too long for a decision to become looked after and our responses are not timely or robust enough to ensure risk was reduced.
- The quality of our plans and weak managerial oversight are not driving practice and outcomes for children and young people sufficiently.
- We are not creating conditions for social work to thrive across the whole service, with some social work caseloads being too high in parts of the service.
- Children and families experience too many changes in social worker.
- Corporate parenting needs strengthening to ensure improvement takes place across all practice areas for looked after children.
- Early help is not fully established or understood enough across the partnership (council and CSCB).
- There is insufficient line of sight to the front line.
- The LSCB does not understand the experiences of children and young people and has failed to sufficiently monitor and evaluate the effectiveness of front-line practice (CSCB).
- The LSCB lacks direction and purpose and does not provide effective challenge to poor practice and risks to vulnerable children in Croydon (CSCB).

Areas of stronger practice

- Improvements in timeliness and oversight in the Multi Agency Safeguarding Hub, since the Joint Targeted Area Inspection in May 2016.
- Most looked after children live in stable placements where they are well cared for.
- Children, parents and carers are engaged in reviews, and independent reviewing officers (IRO's) "know children well".
- Improvements in the availability of performance data.
- Work to strengthen partnerships and understand local need.
- Strong partnership working with the Home Office to ensure that Unaccompanied Asylum Seeking Children are cared for, including liaising with other areas as part of the national dispersal scheme. This is recognised nationally.
- Effective multi-agency work for girls at risk of female genital mutilation.
- Effective arrangements for tracking children who are missing from education.
- A high proportion of children looked after live with a foster family.
- The LSCB has led the overall strategic approach to CSE and children missing and has raised awareness across a range of settings.

7. ACTION TAKEN SINCE THE INSPECTION

7.1 Following the feedback received during the inspection, a corporate improvement programme led by the Chief Executive has been developed. This includes an improvement team bringing together the Executive Leadership Team and senior officers across the council to drive the improvement needed and the development of a transitional action plan, which will target improvements in the next 2-3 months

7.2 A summary of the action taken since the inspection is included below:

Leadership and governance

7.3 A Children's Service Improvement Board has been established, which will be chaired by an independent chair, Edwina Grant OBE, who has recently been appointed. This Board will bring together officers and elected members from the council, partners, external support, the LGA, the DfE and the commissioner who will meet on a monthly basis to provide oversight and challenge to the improvement programme. A shadow board meeting took place in August and the Board formally launched on September 5.

7.4 The engagement of a strategic improvement partner, Achieving for Children, who will begin providing support to the council in September. In addition, the London Children's Services advisor from the Local Government Association (LGA) will offer advice and support to officer and members.

7.5 A meeting has also taken place with our Department for Education (DfE) case officer, John Bostock, who attended the initial shadow board improvement board on 16th August.

7.6 The Chief Executive and Executive Director-People have made visits to neighbouring local authorities who have also been judged as inadequate (Wandsworth and Bromley) to see what lessons can be learned about the improvement journey for children's services and how pace can be accelerated.

7.7 There have been appointments to a number of key leadership and management positions. An interim Director of Early Help and Children's Social Care has been appointed with significant experience in this area from Kent County Council. Two new permanent Heads of Service have been appointed and will join Croydon in October. In addition, an interim Chair of the Local Safeguarding Children Board has been appointed.

7.8 A series of engagement activities with children looked after are taking place over the summer holidays in order to strengthen and relaunch the children in care council, which will formally re-launch in October half term.

Workforce actions

7.9 An additional interim social work team has been created in order to reduce caseloads in care planning. A unit manager and three social workers are in post and recruitment is ongoing to fill the remaining three vacancies.

7.10 All newly qualified social workers (ASYE's) have been spoken to, and immediate actions taken to better support them. Caseload numbers have been reviewed and those ASYEs who had highest caseloads have had their caseloads reduced.

7.11 The recruitment of two additional auditor roles has taken place and they are now in post. These will provide additional assurance on individual casework practice.

7.12 A learning and development programme has been commissioned for first line managers, which will be mandatory, and will commence in September.

7.13 The development of a strong workforce strategy and recruitment campaign has started led by corporate HR and communications teams, with strong service collaboration.

Social work practice

7.14 The post of principal social worker has been established and this post holder will be key to driving improvement in social work practice.

7.15 Additional auditing including external audit activity has taken place and will continue to be a key part of the improvement programme in order to provide additional assurance about the quality of practice.

7.16 LGA Children's Improvement Advisor has undertaken sessions with first line managers on strengthening supervision and understanding what good looks like.

7.17 Initial sessions have taken place to consider the model of social work practice that best fits Croydon to support improved outcomes for our children and creating positive conditions for our social workers to thrive.

7.18 There has been a strengthening of the tracking processes across the service in order to prevent drift and delay.

7.19 Work is taking place to relaunch the process for undertaking return home interviews for children who go missing.

7.20 Senior managers have also met with members of the judiciary to support improvement planning around court work.

Systems and support

7.21 Smartphones are being allocated to all social workers so that they are able to work more flexibly and stay in contact with children and families.

7.22 A project is underway to improve the level of business support provided to social workers and initial workshops with social workers and business support officers have taken place to identify 'quick wins' and systemic barriers.

Communications and staff engagement

7.23 A series of engagement sessions have taken place with newly qualified social workers (ASYEs), social workers, Unit Managers, IROs and conference chairs, Service Leaders, Heads of Service to identify immediate areas for improvement and inform our long term approach to improvement planning.

7.24 A focused programme of engagement with all ASYEs is in place, undertaken by a corporate lead, to better understand their learning and development needs.

7.25 A programme of briefing workshops took place with staff on the 1st September to share the Ofsted report, and to engage them in our response. There is ongoing engagement to both support the development of practice and the improvement plan.

8. IMPROVEMENT PLANNING & NEXT STEPS

8.1 In accordance with the Single Inspection Framework, every local authority must produce an action plan of how it intends to respond to the inspection recommendations, regardless of the final inspection judgement. The local authority must send its action plan within 70 working days of receiving the final report. For the council, this plan must be submitted to Ofsted by the 11th December 2017.

8.2 Following the publication of the report, work has already started on developing a Children's Improvement Plan which sets out the key priorities and areas of focus. A summary of the draft Improvement Framework, including the draft priorities and conditions for success are outlined in Appendix 4.

8.3 A comprehensive engagement programme with children and young people, staff and partners will be undertaken.

8.4 An action planning session is expected to be held with Ofsted in October 2017, which will further refine the actions arising from the findings and recommendations in the report.

8.5 A final Improvement Plan will be presented to a future meeting of the Cabinet with the details of the monitoring arrangements which we will use to assess progress. Before we can start putting the plan into action it will also be signed off by Ofsted and the Department for Education.

9. MONITORING & RE-INSPECTION OF INADEQUATE LOCAL AUTHORITIES

9.1 Ofsted will undertake a series of activities including an action planning visit, a programme of quarterly monitoring visits and a re-inspection once the period of monitoring has ended.

9.2 Ofsted will visit the local authority for an action planning meeting. This will happen between 25 and 35 days after the local authority receive the report. This meeting will cover the inspection judgements and recommendations, including implications for statutory partners, and review the draft post-inspection action plan.

9.3 The local authority has to submit a 'written statement of action' (the action plan) to the Secretary of State and Her Majesty's Chief Inspector (HMCI) within 70 working days of the receipt of the inspection report (11th December). Ofsted will review the action plan and confirm to the Director of

Children's Services whether the action plan reflects the inspection findings and recommendations.

Monitoring of inadequate local authorities

9.4 Ofsted will carry out quarterly monitoring visits which will evaluate the progress the local authority has made against the recommendations in the inspection report.

Re-inspection of inadequate local authorities

9.5 Ofsted decides whether to undertake a post-monitoring single inspection or a full single inspection. This decision is based upon information and performance data gathered during monitoring visits, the local authority's evaluation of its improvement journey and the view of the DfE.

9.6 Ofsted will usually re-inspect a local authority judged inadequate at its last inspection within two years of it submitting its action plan.

9.7 If the re-inspection determines that the local authority remains inadequate, the monitoring process will start again. Alternatively, the Secretary of State may appoint a Children's Services Commissioner to review whether services should be removed from council control.

9.8 Where Ofsted returns a "requires improvement" judgement on a previously inadequate council, central government will continue to provide supervision and support for 12 months to ensure that improvements are sustained. (The Department for Education's intervention policy can be found in Appendix x)

9.9 The authority is subject to intervention by the Department of Education (DfE) until services are improved.

9.10 Whenever Ofsted finds children's social care services to be inadequate, the DfE will provide expert scrutiny to diagnose problems and support the council to produce an effective improvement plan. The DfE has appointed Eleanor Brazil as the children's commissioner to Croydon for an initial three-months to give advice to ministers about the council's progress on improvements. The children's commissioner will write a report to the minister on her findings. This will be a public report and will be published on the central government website. It is anticipated this report will be completed early December, 2017.

9.11 The DfE will review the local authority's progress towards improvement every six months.

10. FUTURE REPORTING

10.1 The report asks that Cabinet receive regular progress reports on the response to the inspection findings along with the Overview and Scrutiny Committee who will lead on scrutinising the overall impact of the improvement programme. The Children and Young Peoples Scrutiny Meeting will provide additional scrutiny with a standing item to focus on a key

theme in the Improvement Plan. This is set out in recommendations in 1.7 and 1.8.

11. CONSULTATION

11.1 Consultation and engagement with children and young people is central to social work practice and service improvement. Croydon has a range of mechanisms to engage and consult with children, young and their families. This includes the delivery of its Youth Engagement Strategy which sets out a number of new initiatives to ensure that children and young people have a voice, including our first Youth Congress held in July 2017 and the Children in Care Council, which will be relaunched in October 2017.

11.2 Listening and responding to the experiences, wishes and feelings of children and young people has been identified as one of the priorities of the improvement plan and will be central to the improvement programme. The plan will include actions to strengthen how the views and experiences of children, young people and their families influence service design. This feedback will also help monitor the impact of improvement activity.

11.3 There will also be engagement, consultation and communication with staff and partners about the inspection result and in the development of the Improvement Plan. This has already started and a Council staff reference group is being established which will feed into the improvement board to ensure the connection and ownership of the improvement programme.

11.4 The Improvement Plan will be a single improvement plan and include improvements that need to be made to the Croydon Safeguarding Children's Board. The delivery of improvements will need to be delivered by the whole Council and with partner agencies to ensure action is undertaken in a joined up and effective way. Partners are included in the Improvement Board to support this.

12. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

£1m has been allocated from earmarked reserves to support the targeted improvement work over the remainder of this year. The impact on future years budget of the improvement work will be considered as the 2018/19 budget is agreed.

Approved by Lisa Taylor, Director of Finance, Investment and Risk

13. COMMENTS OF THE COUNCIL SOLICITOR AND MONITORING OFFICER

The Solicitor to the Council comments that there are no direct legal considerations arising from the recommendations in this report.

Approved by J Harris Baker, Director of Law and Monitoring Officer.

14. HUMAN RESOURCES IMPACT

14.1 Successful implementation of the workforce elements of the improvement plan are central to progress. Without a strong and sustainable workforce the other service improvements will not succeed.

14.2 The review of the salary and benefits package for social work staff will need to be compatible with Croydon's overall pay and grading structures and ensure any changes are compliant with pay policy and equal pay legislation.

14.3 Trade unions will be regularly consulted on proposed changes and the progress on the improvement plan.

Approved by Sue Moorman, Director of Human Resources

15. EQUALITIES IMPACT

15.1 Equalities and diversity considerations are a key element of social work practice. It is imperative that help and protection services for children and young are sensitive and responsive to age, disability, ethnicity, faith or belief, gender, gender, identity, language, race and sexual orientation.

15.2 Croydon has a diverse population of children and young people. Children and young people from minority ethnic groups account for 57%, compared with 30% in the country as a whole. The proportion of children and young people with English as an additional language across primary schools is 44% (the national average is 18%).

15.3 Social workers recording and planning in relation to inequalities is inconsistent and therefore the action plan addresses the additional work which needs to be done to ensure that children's diversity and identity needs are met.

16. ENVIRONMENTAL IMPACT

There are no direct implications contained in this report.

17. CRIME AND DISORDER REDUCTION IMPACT

There are no direct implications contained in this report.

18. REASONS FOR RECOMMENDATIONS/PROPOSED DECISION

18.1 Authorisation to complete and submit the draft Improvement Action Plan is recommended as the local authority is required to submit a 'written statement of action' to the Secretary of State and HMCI (to be submitted by the 11th December 2017).

18.2 A standing item at Children and Young Peoples Scrutiny on the progress of

implementing the work streams in the Improvement Plan will enhance scrutiny by elected members in order to support and challenge continuous improvement. This has been agreed by the Scrutiny Committee so that the local authority is effective as the lead agency for the protection and care of children and young people and as a corporate parent.

19. OPTIONS CONSIDERED AND REJECTED

N/A

CONTACT OFFICER: Sarah Warman, Head of Commissioning & Improvement

Appendices to this report

- Appendix 1. Inspection Report, including the review of the effectiveness of the LSCB
- Appendix 2. Ofsted guidance for inadequate local authorities
- Appendix 3. Department for Education guidance for inadequate local authorities
- Appendix 4. Draft Improvement Framework

Background papers: none

London Borough of Croydon

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: 20 June – 13 July 2017

Report published: 4 September 2017

Children's services in Croydon are inadequate		
1. Children who need help and protection		Inadequate
2. Children looked after and achieving permanence		Inadequate
	2.1 Adoption performance	Requires improvement
	2.2 Experiences and progress of care leavers	Requires improvement
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 their families in Croydon that leave some children at risk of significant harm. Inspectors identified a legacy of poor practice characterised by drift and delay in the provision of key services. Weak managerial oversight at all levels has not ensured that basic social work practice is of a good enough standard. Children do not receive robust and timely responses to ensure that risk is reduced and their needs are met. The local authority was required to take immediate action in a small number of cases identified by inspectors during the inspection.

Since the local authority was inspected in 2012, there has been significant deterioration in the quality of service provision. Poor managerial oversight of cases fails to ensure that basic social work practice is of a good enough standard. This means that not all children receive help in a robust and timely manner. The workloads of social workers in some teams are high and this presents a serious barrier to providing effective services for children. The turnover of staff in many teams, coupled with the many transition points, further inhibits the building of trusting relationships between social workers and children.

When children are missing or are at risk of sexual exploitation, poor recognition and response to these concerns is not reducing risk to them effectively. Too few children looked after who go missing are spoken to when they return, therefore the understanding of associated risks is weak. While strategic partnership understanding has improved, the response to children who are at risk from sexual exploitation is underdeveloped. When circumstances for some children do not improve, the local authority is either too slow to take action or reduces the level of support without evidence of demonstrable progress. This means that some children remain in harmful situations for too long.

Too many children wait too long for a decision to be made as to whether they need to be looked after, or they return home without sufficient support. This has left them at risk of significant harm from neglectful parenting. The pre-proceedings phase of the Public Law Outline (PLO) is not used often enough or early enough to ensure that parents are aware of the potentially serious consequences of poor or harmful parenting.

The chief executive and current director of children's services (DCS) recognised the breadth and depth of this decline and they commissioned a number of detailed external service reviews on their appointments in July 2016. The local authority is at a very early stage in addressing the poor practice identified. Some improvements have been made, for example in the multi-agency safeguarding hub (MASH). However, action plans to address deficits are focused on process or structure and there is insufficient consideration of improving outcomes for children. This has created delay in addressing and targeting the areas of greatest concern.

Most children looked after live in stable foster placements where they are cared for well. However, many carers feel poorly supported and the fostering service is not compliant with all regulations. There is good consideration of most children's diverse needs in placement matches. In the majority of cases, social workers see children regularly, although evidence of purposeful direct work is more limited.

Political leaders and chief officers say that vulnerable children are a top priority for the council. Effectively supporting such a high number of unaccompanied asylum seekers is a formidable challenge that has been a priority. However, this prioritisation is not having the same impact on the rest of the frontline services. There has been political and senior leader support for increasing capacity at senior manager level and there have been some recent appointments to additional manager posts. There is evidence of some recent improvements, including a strengthening of work within the MASH. This has led to more effective management oversight of practice by a dedicated project manager who oversees all decisions within 24 hours. A specialist team of social workers and managers works closely and effectively with the Home Office to ensure a strong and caring initial response to children arriving alone in the country.

The range and coordination of early help provision for children and families are not fully established. Individual partner agencies are unclear about the early help offer and have not been involved in developing a shared approach to delivering services. Inconsistent application of thresholds and a lack of recognition of risk are commonly evident in assessments and plans, including where risks escalate. Multi-agency participation in and contribution to the support of children in need are not robust or sufficiently effective.

A lack of challenge from the Local Safeguarding Children Board (LSCB) has not assisted in raising safeguarding standards in the local authority. It is too soon to see the impact of engagement of key strategic partners in improving services for children, as services are newly commissioned or are at the planning stage and there is not yet an evaluation of improvement.

More recently, children who cannot live with their families have been increasingly considered for adoption, but delays remain. The quality of children's permanence reports (CPRs) is variable. Adopters are assessed well and report being supported. The large majority of care leavers are in education, employment or training and they report strong and consistent support from their personal advisers. However, not enough young people live with their foster carers beyond the age of 18. Too few care leavers have the opportunity to move to independent accommodation when they are ready to do so. Preparation of young people for independent living is inconsistent and not all are fully aware of their entitlements. The quality and timeliness of pathway planning are too variable.

The corporate parenting panel expresses a commitment to improving the lives of children. However, the local authority overall has not prioritised and planned sufficiently to improve outcomes for enough children.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates one children's home, which was judged good in its most recent Ofsted inspection.
- The previous inspection of the local authority's safeguarding arrangements was in May 2012. The local authority was judged adequate.
- The previous inspection of the local authority's services for children looked after was in May 2012. The local authority was judged adequate.

Local leadership

- The DCS has been in post since July 2016.
- The DCS is also responsible for adult services.
- The chief executive has been in post since July 2016.
- The chair of the LSCB has been in post since March 2016.
- The local authority uses a systemic model of social work.

Children living in this area

- Approximately 93,435 children and young people under the age of 18 years live in Croydon. This is 25% of the total population in the area.
- Approximately 23% of the local authority's children are living in low-income families.
- The proportion of children entitled to free school meals:
  - in primary schools is 19% (the national average is 15%)
  - in secondary schools is 17% (the national average is 13%).
- Children and young people from minority ethnic groups account for 58% of all children living in the area, compared with 21% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are African and Caribbean.
- The proportion of children and young people who speak English as an additional language:
  - in primary schools is 36% (the national average is 20%)
  - in secondary schools is 26% (the national average is 16%).

[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.

- Croydon has a high number of unaccompanied asylum-seeking children (364 as at 19 June 2017), which is 48% of the total children looked after population.

Child protection in this area

- At 19 June 2017, 1,789 children had been identified through assessment (in the previous 12 months) as being formally in need of a specialist children's service. This is a decrease from 1,839 as at 19 June 2016.
- At 19 June 2017, 399 children and young people were the subject of a child protection plan. This is an increase from 360 at 31 March 2016.
- At 19 June 2017, 37 children lived in a privately arranged fostering placement. This is an increase from 18 at 31 March 2016.
- Since the last inspection, 14 serious incident notifications have been submitted to Ofsted and 11 serious case reviews (SCRs) have been completed or were ongoing at the time of the inspection.

Children looked after in this area

- At the time of inspection, at 19 June 2017, 760 children were being looked after by the local authority (a rate of 81.5 per 10,000 children). Of this number:
  - 324 (43%) lived outside the local authority area
  - 15 lived in residential care homes, outside the authority area
  - four lived in residential special schools[3] and they lived out of the authority area
  - 648 lived with foster families, of whom 40% lived out of the authority area
  - seven lived with parents, of whom 43% lived out of the authority area
  - 364 children were unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been 20 adoptions (June 2016 to May 2017)
  - 20 children became subject to special guardianship orders
  - 515 children ceased to be looked after, of whom 5% subsequently returned to be looked after
  - 433 young people ceased to be looked after and moved on to independent living
  - 270 young people ceased to be looked after, and are now living in houses in multiple occupation.

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

Recommendations

1. Ensure that managers have sufficient oversight of practice, and provide social workers with effective, clearly recorded supervision to support good social work practice.

2. Establish a stable workforce through purposeful recruitment and retention activity that includes targeted training for frontline staff and managers so that they have the skills and knowledge to better protect and care for children. Take steps to ensure that the workloads of social workers are manageable, and that they have sufficient time to complete essential work.

3. Ensure that there is appropriate and timely action with regard to understanding and reducing risk to all children, especially those at risk of sexual exploitation and those who go missing from home or care. Ensure that social workers have the necessary skills and knowledge to help children at risk of sexual exploitation.

4. Ensure that children missing from home or care have every opportunity to speak to an independent person about the reasons they go missing so that appropriate action can be taken to effectively support them, and reduce risk.

5. Ensure that all plans for children contain achievable, realistic goals and that timescales and contingency planning are specific, and include sufficient support for children who return home. Ensure that the individual needs of brothers and sisters are identified and met.

6. Ensure that thresholds are rigorously applied at all levels, including care thresholds and the timely and proportionate use of the pre-proceedings phase of the PLO, so that children who cannot live with their parents find permanent alternative homes as quickly as possible.

7. Ensure that strategy discussions include information gathered from all partners, and result in clear planning and recording of actions and the rationale for decisions.

8. Review the roles and responsibilities of managers at all levels in relation to decisions about children's permanent care, to ensure that they are confident and competent enough to make these decisions. Establish robust tracking processes to ensure that plans are progressed and delay is minimised.

9. Ensure that there is routine and comprehensive oversight of all decisions and actions relating to children who are subject to pre-proceedings or court proceedings, to eliminate all avoidable delay in deciding permanent arrangements for children.

10. Ensure that child protection conference chairs and independent reviewing officers (IROs) provide appropriate challenge that prevents drift and delay in planning for children. Ensure that formal escalation systems are used to record and monitor actions raised, to make sure that purposeful work is done in order to achieve improved outcomes for children.

11. Strengthen the provision of early help support for children and families and ensure that partner agencies have a shared understanding of the early help strategy and associated thresholds.

12. Improve the quality of assessments to take account of individual children's needs, including historical information, and ensure that all information is rigorously analysed and updated when circumstances for children change.

13. Ensure that the fostering service appropriately supports foster carers, and that the work of this service meets all relevant regulations.

14. Improve permanence planning across the wider service to ensure that the planning and timeliness of adoption improve for all children. Ensure that there is focused family-finding activity for children with adoption plans, to minimise delays.

15. Review the provision and take-up of advocacy and independent visitor services to ensure that all children who would like this can access these services.

16. Ensure that appropriate assessments identify children living in private fostering arrangements.

17. Ensure timely pathway planning and ensure that plans are specific, accurate and detailed, and include contingency planning, to support good outcomes for all care leavers.

18. Ensure that staying-put arrangements are promoted to all care leavers and foster carers, so that care leavers who want to stay with their former foster carers can benefit from greater permanency and support as they move towards independent adulthood.

19. Ensure that young people move on to independent accommodation only when it is the right time for them to do so. Improve the help/assistance provided during their transition to independent living through more consistently good preparation and support. This should include accurate, comprehensive and up-to-date information about young people's rights and entitlements.

20. Ensure that elected members, as corporate parents, prioritise and focus on improving all areas of poor practice for children looked after and care leavers.

21. Strengthen training and work on complaints and embed a culture of feedback. Improve the analysis of complaints and the understanding of the reasons why children, families and foster carers complain, in order to address issues raised.

Summary for children and young people

- Too many services for children and young people in Croydon are poor. This means that not all children are kept safe from harm or are helped early enough.
- Senior leaders know that services need to be better, but they have taken too long to take action to improve them.
- When professionals tell social workers that they are worried about children and young people, not all available information is collected to help them to decide quickly what services will best support them and their families.
- Managers have not made sure that all social workers have enough time to ensure that children and young people are visited often in order to understand how they feel and what they need. This means that they do not always gather all the information they need to understand what life is like for children and young people in Croydon, and to make plans to help them improve their lives.
- Too many children and young people in Croydon have too many different social workers, which means that it is hard to trust and make positive relationships with their social workers as they change too often.
- Managers are not giving social workers the help that they need in order to make sure that they are getting things right for children and young people, and taking action that will help them quickly enough.
- When children and young people are missing, there is not always enough information gathered about the risks that they face. This means that the risks to children and young people, especially dangers from adults sexually exploiting them or from gangs, are not always known and the best help and support are not always given.
- Managers are not making decisions quickly enough when children need to come into care. It also takes too long for some children and young people to get to know where they will live until they are adults. Not enough children and young people are staying with their carers after they are 18 years of age.
- Most children and young people who live with foster carers feel settled with carers who know them well and who listen to them.
- Recently, more children have had plans to be adopted and, once this decision is made, they receive a better service.
- Most care leavers have workers who they like and trust and many young people are working, training or in further education. However, too few young people leaving care move to live independently and many are not helped enough to know how to manage money and how to look after themselves well.

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

Summary

Services for children in need of help and protection in Croydon are inadequate. Serious and widespread failings leave some children at risk of significant harm. Weak managerial oversight at all levels has not ensured that basic social work practice is of a good enough standard. Children do not receive robust and timely responses to ensure that risk is reduced and their needs are met. The local authority was required to take additional steps in some cases during the inspection to be assured that the children were not at immediate risk of harm.

The inconsistent application of thresholds and a failure to recognise risk are common features in too many cases. When circumstances for children do not improve, the local authority is too slow to take action. This means that some children are left in harmful situations for too long.

The workloads of some social workers, in some teams, are too high. This is a serious barrier to their providing effective services for children. There is too great a turnover of staff in many teams, which makes building trusting relationships between social workers and children difficult.

The range and coordination of early help provision for children and families are underdeveloped. However, partner agencies are at the early stages of working together to develop a new, shared approach to delivering services.

Most assessments do not effectively consider history or parental capacity or analyse risk. Additionally, the majority of children's plans are not of good quality, and are too narrowly focused. Progress is often limited and actions are not achieved before plans are closed. Work with some children drifts without reassessment or analysis of change.

Child protection chairs and partner agencies are not currently using formal systems, child protection conferences and core groups to effectively challenge drift and delay in planning for children.

When children are missing or they are at risk of sexual exploitation, the recognition of and response to these concerns are not effectively reducing risk to them. Stronger arrangements are in place for tracking children who are missing from education.

The local authority has undertaken awareness raising to protect children from radicalisation and to take appropriate action to support children who are at risk.

Effective multi-agency services for girls at risk of genital mutilation are in place.

Inspection findings

22. For too many children, risk is not consistently recognised and responded to at the right level or at the right time and previous concerns about children are given insufficient consideration. When risks to children escalate, or do not reduce, the local authority fails to intervene quickly enough.

23. The workloads of some social workers and team managers, in some teams, are too demanding in both volume and complexity. Some staff told inspectors that they are overwhelmed by the amount of work, and are unable to complete essential tasks, such as visiting children regularly and completing assessments within timescales.

24. Too many changes of social worker mean that many children miss the opportunity to build trusting relationships with their social workers. Some newly allocated workers then struggle to capture a genuine understanding of children's lived experience, by routinely reading the history or taking account of, and building on, previous social work to progress children's plans. This means that social workers have to start over again for too many families.

25. Management oversight and supervision of social work practice in many teams, while regular, are not effective. Social workers do not receive sufficient support, direction or challenge to ensure that children receive effective and timely help.

26. The range and coordination of early help provision for children and families are underdeveloped. Partner agencies remain unclear about the purpose of the early help offer. However, they are at the early stages of working together to develop a new approach, building on the Best Start Programme, which is helping to further develop a shared approach to delivering services. The early help hub facilitates access to services and supports professionals in completing early help assessments. However, there is an insufficient range of evidence-based interventions to support families. The evaluation of work is not taking place, which means that it is difficult to measure impact or demonstrate that the work is sustainable and is making a difference for children. (Recommendation)

27. The early help screening and assessment process builds delay in decision-making processes and operates separately from children's social care systems. Non social work staff can hold cases for several days without the early help screening team making a decision. For example, some cases wait too long before being allocated for a social work assessment.

28. Action taken by the local authority to address the deficits identified during a joint targeted area inspection (JTAI) of MASH arrangements 12 months ago has resulted in better practice, with more effective management oversight of work in the MASH. There is more timely and robust management action taken by a dedicated project manager, who signs off all decisions within 24 hours. Daily MASH discussions take place to effectively share information and agree actions on individual cases.

29. The understanding and application of statutory thresholds both by the local authority and by partner agencies are inconsistent. The number of contacts that lead to no further action continues to be high at 60%, although this has reduced from 80% at the time of the JTAI. Several different referral pathways into children's services exist and this is confusing for partners, and means that some contacts are made through the wrong pathway. (Recommendation)

30. Strategy discussions, though mostly timely, generally take the form of a telephone call with the police child abuse investigation team (CAIT). Other relevant agencies are not routinely involved, which means that multi-agency sharing of comprehensive information is not available to inform decisions. A high number of child protection enquiries (63%) do not lead to an initial child protection conference. This means that there may be another missed opportunity for multi-agency discussion and a shared approach to planning for children. (Recommendation)

31. The quality of assessments overall is mostly poor. Information is not rigorously analysed and there is insufficient consideration of families' historical information. Children's identity and cultural needs are not fully explored during the assessment process. While the views of children and their parents are recorded in the majority of cases, meaningful work with children in order to really understand their lived experiences is weak. Brothers and sisters are referred to collectively in assessments and many children's individual needs are overlooked. Some children who live in families in which there is a particular focus on one child are not referred to in assessments. Assessments are not routinely updated and new information is not analysed to reflect what may be significant changes in children's circumstances. (Recommendation)

32. Clear practice standards or recognised tools to assess levels of neglect are not used to inform assessments and, in too many cases, the impact of chronic neglect on children is not fully addressed.

33. Too many child in need and child protection plans are narrowly focused and goals and timescales are not clear enough. Specific contingency planning is missing. This means that some families do not understand the consequences if progress is not made to address concerns. Social workers do not visit all children regularly enough to monitor whether plans are making a positive difference to their lives. Brothers and sisters are considered together on shared plans and in the vast majority of cases these do not consider or address their individual needs. In many cases, child protection plans are ceased too soon, before sufficient progress has been made. For example, in some cases, plans end when parents have just started to engage in work to address long-standing domestic abuse, even though their ability to make and sustain improvement has not been demonstrated. (Recommendation)

34. The quality of social work for disabled children is variable. There are some stronger examples in the specialist team of whole-family assessments and work to support brothers and sisters. However, practice is less effective when there are presenting safeguarding concerns. Workers do not recognise and take timely action to address neglect for all of these children, reflecting the poor practice found in other teams.

35. There are a very small number of cases that have good-quality assessments, plans and recordings, where social workers go the extra mile to ensure that children's thoughts and feelings are reflected in their plans and case records.

36. Core-group meetings take place regularly. However, professionals in core groups do not all ensure that plans are used to measure and promote improvement and they do not challenge each other when there is delay in progress. This leads to a lack of purposeful and effective work and too many children experience unacceptable drift and delay.

37. Child protection conference chairs do not consistently provide effective challenge or use the formal alert system to highlight poor practice. Child protection chairs often have informal conversations with social workers and managers which are not recorded. This means that it is difficult to monitor agreed actions and progress. (Recommendation)

38. Advocacy is not well promoted or well used for children and young people in Croydon. Inspectors did not see any cases where advocacy had been offered or used to support children in need of help and protection, or to support their parents, to help them understand and fully participate in the process.

39. Responses to the needs of children who go missing are weak. Return interviews are not taking place for the majority of children, which means that the opportunity to gather critical information, identify risks and take timely protective action is lost.

40. Recognition of the risks to children from sexual exploitation is poor. Most social workers do not have sufficient knowledge and understanding of sexual exploitation to enable them to help children. Recognised models and tools for assessing the risk of child sexual exploitation are not used and the majority of staff have not received training in the skills needed to support children who are exploited. (Recommendation)

41. Inspectors found that social workers lack a consistent understanding of what constitutes a private fostering arrangement. Several cases were seen where an assessment should have been completed to ensure that children were appropriately cared for, which means that some children live in circumstances where the suitability and commitment of carers are unknown. (Recommendation)

42. The designated officer arrangements for considering allegations or concerns about staff or volunteers are in place and strategy meetings are proportionate. However, there is no formal tracking system to ensure that work is completed and within timescales, which means that the implications for some children are not known and acted on.

43. There is an effective commitment to partnership working between the multi-agency public protection arrangements (MAPPAs) and multi-agency risk assessment conferences (MARACs). MARACs are well attended by relevant partner agencies and there is timely reporting on actions. However, too many children living in families affected by domestic abuse do not receive the appropriate level of help and protection to substantially reduce risk.

44. There are effective responses to girls in Croydon who are at risk of genital mutilation. A comprehensive risk assessment tool is in place and its use is leading to better identification of the risk of female genital mutilation. A dedicated health worker efficiently coordinates links across relevant agencies, and promotes the education of parents and community groups. A range of professionals from other agencies and local authorities have benefited from understanding their approach.

45. The local authority has undertaken effective awareness raising about the risks to children of extremism and radicalisation. Training has been provided to the majority of schools in the area and appropriate referrals are made to the 'Channel' panel.

46. There are effective arrangements for tracking children who are missing education. The children missing education welfare officer works closely with schools to ensure that children missing education are identified quickly. Education welfare officers work closely with schools and other partners to ensure that children return to school and improve their attendance. Alternative provision meets the needs of children and young people effectively. Children who are electively home educated (EHE) are well monitored. The EHE officer ensures that all families who are considering EHE are offered and receive home visits or face-to-face meetings. The EHE officer contacts a wide range of appropriate agencies to identify any potential risks to children whose parents do not engage.

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

Summary

Services for children looked after by Croydon are inadequate. Inspectors identified too many children who have waited too long for a decision to be made as to whether they should be looked after, or who have returned home without sufficient support. The pre-proceedings phase of the PLO is not used often or early enough to ensure that parents are aware of the potentially serious consequences of poor or harmful parenting. Parallel planning is not embedded, and drift and delay adversely affect children at all stages of care planning.

Too few children looked after who go missing are spoken to when they return, and the analysis of associated risks is weak. The response to children who are at risk from sexual exploitation is also underdeveloped, and assessments and plans to reduce future harm are rarely evident.

Most children looked after live in stable foster placements where they are cared for well. However, many carers feel poorly supported, and the fostering service is not compliant with all regulations. In the majority of cases, social workers see children regularly. However, there is limited purposeful direct work to help them.

Children's health assessments and reviews are increasingly timely. Children, parents and carers engage with statutory reviews, and most meetings are a comprehensive account of children's lives. Overall, IROs know children well, but they do not always stay in touch with all children between children's reviews and they do not challenge delay assertively enough.

Teachers find the involvement of the virtual school helpful, but the majority of personal education plans (PEPs) need to be improved.

Children who cannot live with their families are increasingly considered for adoption, but delays exist. The quality of CPRs is variable. Adopters are well assessed and supported.

Not enough young people live with their foster carers beyond the age of 18 years. Too few care leavers have the opportunity to move to independent accommodation when they are ready to do so. Preparation of young people for independent living is inconsistent and not all are fully aware of their entitlements. The quality of pathway planning is too variable. However, the large majority of care leavers are in education, employment or training, and they report strong and consistent support from their personal advisers.

Inspection findings

47. Too many children wait too long for a decision to be made as to whether they should be looked after and this means that they continue to live in neglectful or harmful situations for longer than is necessary. If they return home from care, plans and packages of support are not always sufficiently robust to avoid problems recurring.

48. Senior managers have been very slow to adopt the pre-proceedings phase of the PLO, which is a legal requirement. This means that an important step in engaging with families and planning for children's legal permanence is bypassed and parents do not always have the opportunity to change their behaviour, or have a clear understanding of the consequences of not doing so. Although the number of children in pre-proceedings is increasing, it is still too low. Child protection plans that are not effective continue for too long when more decisive action is needed and when the care threshold is likely to be met. This leaves children at risk of further harm.

49. Until recently, the tracking and oversight of pre-proceedings, court work and permanence planning were significantly underdeveloped. This created delays for children at all stages, from the decision that the legal threshold for care proceedings is met, through to a permanent placement match being decided. Inspectors saw a number of cases where children have experienced drift and delay due to assessments not being commissioned or completed on time, or statements and applications submitted to court late. This slows children's journeys towards secure and permanent homes. (Recommendation)

50. The determined work of the care proceedings manager, appointed in September 2016, and the recent increased attention of senior managers are beginning to have a positive effect on services, from a low base. Inspectors noted some improvements in the oversight of care proceedings and pre-proceedings from April this year. Targeted training and mentoring of staff are increasing their skills. These early signs of change are also reported by the Child and Family Court Advisory and Support Service (Cafcass), which has noted that, although practice remains inconsistent, the timeliness and quality of court assessments and care plans are improving.

51. A permanence policy, introduced in January 2017, ensures that staff increasingly understand what is expected of them. However, senior leaders have been much too slow to establish minimum standards and these are not embedded in practice. Permanency planning meetings are not always ambitious or assertive enough to ensure that a range of permanence options are considered and pursued for children of all ages. This demonstrates a lack of ambition to achieve the best positive permanence option for all children. Contingency and parallel planning are often not evident and this leads to avoidable delays for children when a preferred care plan, such as a family care arrangement, proves to be unviable. (Recommendation)

52. Children are thoroughly matched with long-term permanent carers, but delays are evident. Some children wait for up to a year to know where they will live for the remainder of their childhood and beyond. Foster carers told inspectors that this is difficult and unsettling for children. Once decisions have been made, it is positive that social workers and managers mark these important events with certificates and celebratory activities.

53. Although case supervision is regular in most cases, and there are some detailed updates and actions, close attention to overall care plans for children and purposeful challenge of delay are rarely evident. In a number of cases important risk factors are not sufficiently explored and in a few cases they are not mentioned at all. Clarity about accountability for important decisions for children looked after is not established or evident in recording.

54. When children go missing from care, they are rarely spoken to about their experiences. When a conversation is offered, children often refuse to engage. A lack of persistence and creativity in considering why children run away, whom they are with, where they go and the risks they face, is a key weakness. This is because it limits professionals' understanding of children's lives and reduces opportunities to make them safer. Leaders and partners have put in place appropriate strategic arrangements, including a commissioned service that provides high-quality support. However, practice is highly inconsistent; comprehensive risk assessments and assertive planning to safeguard children are rare, leaving them vulnerable to harm. (Recommendation)

55. Most social workers who spoke with inspectors demonstrated an understanding of children's lives and histories. Better performance information is enabling managers to monitor some important aspects of support for children looked after, including the frequency of social work visits. Visits are regular for the majority of children, including those who live out of the authority area, although records do not always evidence purposeful direct work with children. Some children wait too long for important direct work, such as life story work, but inspectors also saw some good examples of creative time spent with children, including singing, using pictures to help them to understand their country of birth and playing make-believe games. Children told us that they see their social workers often and most find them friendly and helpful.

56. In the first quarter of 2017–18, only 13 children looked after were supported by an advocate and this means that very few children have the benefit of an independent supporter who can help them to express their views, challenge their plans, or raise something that they are worried about. There is a waiting list for children who have asked for an independent visitor. When children do spend time with independent visitors, they value this support and friendship. (Recommendation)

57. It is positive that a high proportion (85%) of children looked after live with a foster family. Placement stability is good. Less than one in 10 children moved placements more than twice in the 12 months preceding the inspection. There is sufficient choice for children with regard to in-house foster carers and independent fostering agencies. Almost half of Croydon's 760 children looked after cohort are unaccompanied asylum-seeking children. Inspectors saw detailed age assessments and some positive matches of children with carers who understand and celebrate their culture and faith. However, a small minority of less well-matched children are losing touch with their culture or language.

58. Croydon has some highly committed and skilled foster carers who are providing good-quality care to children. The foster carers who spoke with inspectors talked warmly and protectively about the children they are caring for. A strong commitment to children looked after as much-loved members of families is commonplace among these carers. One foster carer said, 'We are very lucky to have him in our family.' Children told us that they are happy and settled with their carers: 'They are like my mum and dad'; 'We do fun things together like other families'; 'They sort out injustice at school'; and, 'If I'm feeling down she always asks me about it.'

59. However, most carers expressed dissatisfaction with the support provided by the fostering service. A recent independent review identified similar concerns, including a lack of out-of-hours support, irregular supervision, poor communication, lack of delegated authority, insufficient consideration of matching for children and carers not being listened to when they try to challenge poor care planning. The fostering service is not consistently compliant with regulatory standards; unannounced visits are irregular, annual reviews are delayed and delegated authority is not consistently in place. Inspectors also identified children living in unregulated placements where emergency and viability assessments are delayed or not completed within timescales, so that potential risks relating to these households are not fully understood. (Recommendation)

60. The headteachers and designated teachers who spoke with inspectors said that the virtual school team provides helpful support and challenge. They reported that this has improved during the last year. Although the virtual school team has provided training for social workers and designated teachers, the quality of the majority of PEPs requires improvement. Key areas for improvement included the quality of target setting and recording the use of pupil premium funding and the voice of the child. Some children told inspectors that within their PEP meetings they are not praised enough for the things they have achieved. At the time of the inspection, the introduction of e-PEPs, to support quality improvement, was imminent.

61. Most children looked after attend good or outstanding schools and none attends schools judged as inadequate. The virtual school team works closely with the small number of schools that require improvement, to ensure that they receive the support that they need. Children looked after in Croydon achieve less well than their peers in neighbouring authorities and nationally at each key stage of education. Results at key stage 4 are improving, but remain just below the national rates. This improvement is a significant achievement due to the high proportion of children looked after who are unaccompanied asylum-seeking children, many of whom have minimal previous experience of education and speak little English on their arrival. The virtual school team has ensured that good arrangements are in place for unaccompanied asylum-seeking children to enrol in schools quickly. Courses for speakers of other languages are quickly sourced for those who need to improve their English. In addition, a short course is provided for those children who have had very little or no formal education prior to their arrival in the United Kingdom.

62. Local authority officers monitor and support schools well to ensure that all children are aware of the dangers of extremism and radicalisation as well as what to do if they experience bullying or the inappropriate use of social media. Survey responses indicate that the number of children who report experiencing bullying is falling. Children looked after told inspectors that their foster carers and teachers have acted quickly to stop bullying when children have experienced this at school.

63. The local authority ensures that all alternative education provision takes place with registered providers. All children who attend these providers receive full-time timetables. In addition, a registered tuition service, 'Springboard', provides bespoke support to children, most of whom have medical or complex special educational needs. A small number of children looked after are supported through the tuition service and have part-time timetables.

64. Senior managers and partners have worked together to improve the timeliness of initial health assessments from a low base. However, children looked after nurses are not always notified quickly enough when children come into care, leading to delays in some children's health needs being understood. Children looked after nurses acknowledge that greater specificity in health-related actions would improve consistency of follow-up and oversight of children's health needs. Children looked after nurses increasingly engage creatively with hard-to-reach young people, but they have insufficient capacity to be closely involved in children's day-to-day care plans, for example by attending statutory reviews.

65. Although over 80% of children looked after are allocated within the permanence service, the remainder are allocated to social workers in over 25 teams and units. This presents a significant challenge for senior managers in achieving consistency of practice across the service. It has also made it more difficult for the child and adolescent mental health service (CAMHS) to ensure that all social workers know about the children looked after CAMHS provision and associated consultation offer. Although some positive work is taking place, inspectors reviewed a number of cases where children or carers who need therapeutic support have waited too long for advice about children's behaviour or direct support, such as play therapy.

66. Assessments are not regularly updated and care plans and reports for statutory reviews do not outline and analyse children's life experiences alongside recent events comprehensively enough to compensate for this deficit. Care plans are brief and rarely include any detail about children's day-to-day lives, aspirations or overall plans for permanence. This reduces the ability of social workers, carers and professionals to ensure that they are working together purposefully to improve children's outcomes.

67. Statutory reviews are increasingly timely, although too many are still late, due to an inefficient system for arranging meetings. In most cases, children, carers and parents engage with or contribute to these meetings and the majority of records are comprehensive accounts of children's lives and achievements. In most cases, contact arrangements with friends and family members are considered well. Some children told inspectors that reviews are too long and that they sometimes feel that adults are talking about them, not with them. IROs have established long-term relationships with some children, but they acknowledge that they have insufficient time to stay in close touch with children to progress their plans. Inspectors saw some evidence of IROs providing challenge regarding children's care plans, but high-level intervention was not evident enough in those cases where children have experienced most delay.

The graded judgement for adoption performance is that it requires improvement

68. The number of children leaving care through adoption in Croydon is slowly rising. Since June 2016, 32 children who have a wide range of needs, ethnic backgrounds and ages, and groups of brothers and sisters, have been placed for adoption, of whom 22 children have been successfully adopted, including three children placed under foster to adopt arrangements. This performance has improved from 2015–16 as a result of continued focus on making earlier decisions and an increased number of decisions with regard to children to be placed for adoption: 19 in 2015–16, rising to 44 in 2016–17, and this trend is likely to continue into 2017–18.

69. The local authority has recently identified that permanency planning for children across the wider service is weak and needs improvement. Inspectors saw that the impact and legacy of this are that children are waiting longer for adoption, for example, where decisions to progress pre-proceedings within the PLO and care proceedings are delayed, and where care planning is poor once children are looked after.

70. While a recent permanence panel and a permanence tracker monitor children's plans for permanence more robustly, these have not provided sufficient scrutiny and oversight to ensure that plans for adoption are strong and timely for all children. Inspectors observed avoidable delays, for example when decisions to achieve permanence are not quick enough, and some delays in family finding that impact on the timeliness of matching for a few children with adoptive families. The local authority acknowledges that improvements in permanence planning are very recent and that this area requires continued focus and robust oversight to improve performance further. (Recommendation)

71. The timeliness of adoptions is improving, but it does not meet the latest published national thresholds on key indicators. This performance links to the legacy of poor permanence planning across the service. It takes too long for a child in Croydon, from becoming looked after, to be living with an adoptive family. However, the recently improved focus on practice with regard to placing children for adoption is resulting in more timely matches to permanent homes for some children.

72. Similarly, on average, most children are still waiting too long to be legally adopted. A systematic focus on and tighter management of permanence planning are needed across the wider service to ensure the timeliness of adoption for all children, once the agency decision-maker (ADM) makes the appropriate decision that this is the best plan.

73. The recruitment and preparation of adopters are thorough, and there is appropriate use of the South London Adoption Consortium for the provision of preparation groups. Adopters met during the inspection reported that their preparation and assessment were well managed and they commented favourably on the professionalism and support provided by the adoption staff. One adopter had specifically chosen Croydon due to a positive recommendation.

74. Prospective adopters' reports (PARs) seen during the inspection showed that comprehensive, checks and references are progressed appropriately, and that prospective adopters are visited regularly and seen alone. This enables their strengths, motivation and ability to parent adopted children to be well considered. However, assessments are not all completed within the six-month timescales, although some delay is appropriate, for example adopters requesting to have a break between stage one and stage two of the process.

75. CPRs are of variable quality. This is acknowledged by managers, the adoption panel chair and the ADM. In the better reports, children's and birth family's details are thorough and include all aspects of the child's life, including relevant decisions and details that may be required in later life. Weaker reports are not clear. They lack important information and do not provide the rationale for decision-making or up-to-date information, which are extremely important in helping children to understand their early experiences. Recent workshops for social workers to improve practice have addressed the quality of reports, but it is too early to see their impact.

76. The local authority works well with the South London Adoption Consortium and other relevant adoption services to match children with adoptive families that meet their needs. Some delay in the family finding process for children waiting was identified during the inspection and tighter monitoring is required in order to improve this in future.

77. The quality of matching reflects a thorough approach once adopters are identified. Adoption placement reports successfully identify children's needs and the ways in which adopters will meet them. Minutes of the adoption panel reflect appropriate scrutiny and challenge, and recorded decisions by the ADM are comprehensive. The adopters met during the inspection who have been matched with children reported that the process was timely and that they were well supported.

78. The adoption panel is appropriately constituted and effective, and has an experienced panel chair. Panel minutes and recommendations for children and adopters are clear, evidencing a well-balanced rationale. ADM decisions are timely and well considered. Issues identified at adoption panel regarding the work and performance of the adoption agency are highlighted in a six-monthly reporting cycle. These are progressed in order to improve learning and practice, for example the provision of workshops for social workers to improve the quality of CPRs.

79. Life story books seen during the inspection are well constructed and appropriate, evidencing a child-centred approach. Later life letters sampled were sensitively written, with attention to the likely emotional response of the child when older.

80. The adoption service provides a range of support services post adoption, including facilitation of direct contact between birth family members, letterbox arrangements, birth records counselling and intermediary support. Experienced staff provide support to adopters and children, including therapeutic services and interventions, and they liaise and commission relevant additional post-adoptive support services if needed. Applications to the adoption support fund result in appropriate support for families and plans are in place to extend this more fully in the future.

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

81. The care leaving team was working with a high number of care leavers at the time of the inspection (705), half of whom were unaccompanied asylum-seeking young people who had become looked after in Croydon. Social workers and personal advisers are in touch with a very large majority of their care leavers (92%) and most personal advisers and social workers are tenacious in their efforts to re-establish contact with those not in touch. Most care leavers receive appropriate help with progressing smoothly to independent living. However, a minority do not receive sufficient support to meet their needs, and are less well prepared for the transition to adulthood.

82. The quality of pathway planning with care leavers is too variable and planning starts too late. Workers begin pathway plans just before the care leaver becomes 18 years of age, rather than in the three months before they reach their 16th birthday. This delay affects their transition to adulthood because establishing relationships with personal advisers does not begin early enough. Not all plans contain sufficient detail or consideration of contingencies and they do not all reflect the views of young people well. (Recommendation)

83. Care leavers benefit from up-to-date health assessments, which are completed by the children looked after nurse before they reach 18 years of age. They receive key information about their health histories. However, while most care leavers receive appropriate healthcare, there are insufficient specific health services available to care leavers to promote and support them after the age of 18, for example specific drop-in clinics for sexual health.

84. Social workers and personal advisers do not ensure that all care leavers are sufficiently prepared for living independently. Care leavers told inspectors of their different experiences of how well they are supported after leaving care. While some talked about very good preparation and support from their personal advisers, including help with learning how to budget and to cook, others said that they were not helped to prepare themselves well. For example, a minority of care leavers got into financial difficulty because no one had told them that they needed to pay council tax when moving to private accommodation.

85. Not enough care leavers benefit from staying-put arrangements. A much lower proportion of Croydon care leavers benefit from living with their former foster carers beyond the age of 18 years than in neighbouring authorities or nationally. Some care leavers and foster carers reported that they believed that staying-put arrangements are only available until the age of 18 if they remain in full-time education. In addition, care plans often say that children will remain in placement until 18 years of age. Both of these factors undermine efforts to ensure that more care leavers benefit from the security and stability of continuing to live with their foster carers as they transition to independent adulthood. (Recommendation)

86. The large majority (78%) of care leavers are in education, employment or training, which is better than rates achieved by neighbouring authorities or nationally. Senior leaders are working to improve opportunities for care leavers in a borough with strong economic growth, for example by expanding existing contracts to ensure that commissioned partners and the authority itself offer apprenticeship opportunities specifically aimed at care leavers.

87. A high number of care leavers have achieved a place in higher education. At the time of the inspection, there were 100 young people taking degree courses and a small but increasing number on higher apprenticeships. These young people continue to benefit from good support provided by their social workers or personal advisers. This support extends to the provision of accommodation for those who want to return to Croydon during university breaks.

88. Not all care leavers are aware of their entitlements, despite this information being included in a well-written care leavers' handbook. Inconsistent support for individual care leavers and a lack of focus in pathway plans mean that not all care leavers have a good understanding of, and access to, their entitlements.

89. The majority of care leavers live in suitable accommodation. However, care leavers have limited options for moving on to independent living when they are ready to do so. More care leavers are living in shared accommodation, following a decision by senior managers to reduce the number of commissioned self-contained housing options. Although care leavers interviewed said that their shared accommodation arrangements were working well, some felt ready, and would prefer, to live independently. The fact that care leavers are not given any priority to help them to secure social housing reduces their options further. A very small number of care leavers are homeless or in emergency accommodation. At the time of the inspection, one care leaver was in short-term bed and breakfast accommodation and, although his circumstances were well assessed and supported, this is not acceptable practice. (Recommendation)

90. Care leavers who met with inspectors held the care leaving team workers in very high regard. They said that their workers were proud of them and their achievements. One said that she regarded her personal adviser and the broader care leaving team as her 'family'. There are also some examples of creative and innovative ideas that are supporting care leavers to be as fully informed as possible about available support. For example, a personal adviser has developed a range of very high-quality YouTube guides under the banner 'former-relevant TV' to help care leavers learn a range of useful skills, including how to select, and use, good-quality private rental websites.

Leadership, management and governance	Inadequate

Summary

Services for vulnerable children in Croydon are inadequate. There are widespread and serious failures in the services provided to children and their families in Croydon that leave some children at risk of significant harm. Senior leaders identified a legacy of poor practice and weak managerial oversight at all levels. However, they have not ensured that basic social work practice is of a good enough standard. The serious and widespread issues across the service had not been fully understood by elected members or senior managers until this inspection and this corporate failure has led to a lack of prioritisation and timely action. This has resulted in too many children remaining at risk of escalating or actual harm characterised by drift and delay.

Work in strengthening partnership working and understanding local need has been more successful. Work has taken place with partners since the JTAI to strengthen the effectiveness of work in the MASH and improve performance management information. This now includes a comprehensive monthly dashboard, performance clinics and performance meetings, including a monthly safeguarding meeting chaired by the leader of the council. However, this monitoring does not translate into commensurate action that improves practice.

Managers, in particular, do not provide enough guidance or direction to social workers to ensure improved outcomes for children. Conference chairs and IROs do not routinely or effectively challenge poorer practice.

The corporate parenting panel has been effective in championing some issues that have led to better outcomes for children looked after, for example improved placement stability and access to education, employment and training. The corporate parenting panel expresses a commitment to improving the lives of children. However, the local authority overall has not prioritised and planned sufficiently to improve outcomes for enough children.

More recent commissioning partnerships demonstrate improvement in some services, but more work is required to ensure that contracts and resources reflect the level of need for children.

The local authority has begun to implement a new recruitment and retention strategy, but work to date has been ineffective in addressing vacancy rates and staff turnover, and in ensuring that there is appropriate support for newly qualified social workers.

Work is taking place to give children a greater strategic voice, but this is yet to translate into practice. The lived experience of a high number of children is unknown or not clearly understood and advocacy to support children is limited.

Inspection findings

91. Work has taken place over the last year to strengthen strategic oversight, management information and structures in Croydon. However, these measures have failed to result in the improvements that are required to ensure that children are safe and well cared for. The serious and widespread issues across the service had not been fully understood by elected members or senior managers until this inspection and this corporate failure has led to a lack of prioritisation and timely action. This has resulted in too many children remaining at risk of escalating or actual harm.

92. Inspectors identified a high number of children for whom a failure to follow procedures has resulted in a lack of care and protection. Inspectors also referred a number of children, for whom there were significant concerns, to the local authority. All of these cases were accepted by Croydon's senior managers and almost all required immediate action to ensure the safety of the children. The local authority has referred one case to the Croydon Safeguarding Children Board (CSCB) for a 'learning lessons' review.

93. Not long after their appointments in July 2016, and in response to growing concerns, senior leaders commissioned a number of detailed external service reviews and undertook two practice weeks, which included all managers across the service auditing and observing practice. Leaders therefore became aware of the serious deficits in frontline practice, but they failed to correctly prioritise the areas of greatest concern. The local authority is at a very early stage in addressing the poor practice identified. However, some improvements have been made, for example in the MASH. Senior managers have put in place an improvement board, an improvement plan, service plans and a range of action plans that are currently focused on improving processes and structures; there is an insufficient focus on the experience of children. This has created delay in addressing the serious and widespread practice issues.

94. There is a dedicated children's and young people's scrutiny committee and regular meetings between officers and elected members, with clear lines of accountability and governance arrangements between political, strategic and operational roles. However, a significant number of meetings and discussions take place informally and there is a lack of formal minutes to demonstrate and evidence accountability and agreed actions. This means that there is no formal record to demonstrate a clear line of sight from elected members and senior managers to frontline practice.

95. Governance arrangements between key strategic bodies are not clear enough. Senior leaders recognise that these require strengthening, and have therefore begun a review of these arrangements. This review includes the Children's Partnership Group, the Health and Wellbeing Board, the CSCB and the local strategic partnership.

96. Croydon is a unique area with very specific challenges, particularly in relation to unaccompanied asylum-seeking children. A specialist team of social workers and managers works closely and effectively with the Home Office to ensure a strong and caring initial response to children arriving alone in the country. This work extends well beyond the borough, liaising with other areas across the country as part of the national dispersal scheme and including involvement in crisis work, such as the Calais camps.

97. The council has sought to strengthen strategic understanding of all children in the borough by building a detailed and relevant picture of the community. This has included the development of strategic partnership arrangements for children at risk of radicalisation and extremism, child sexual exploitation, going missing, trafficking, female genital mutilation and gangs. Together with the police and other partners, 'Operation Raptor' and 'Operation Rosario' have helped Croydon to develop a profile of concerns and increase disruption activity. The borough has also entered into new partnerships and research projects to broaden knowledge about child sexual exploitation and female genital mutilation, and has created a new senior level group to share information about the highest-risk children.

98. Despite this improved cooperation and collaboration at a strategic level, this work insufficiently informs and improves operational frontline practice. Too many frontline practitioners do not follow child sexual exploitation and missing procedures to protect children. Inspectors saw several cases where workers and frontline managers had failed to identify, assess or respond appropriately to children at risk of sexual exploitation. Despite Croydon having one of the highest numbers of missing children nationally, procedures and protocols for children missing from home and care are not fully established or routinely followed. Not enough children receive return home interviews and risk assessments are rarely completed. As a result, vital information that would inform the partnership about these children is lost, which impedes preventative action to avoid further harm.

99. In the last 12 months, senior managers have commissioned an external review of the CSCB. This report found serious failings that resulted in 10 key areas for improvement for the board. The chief executive also challenged the partnership representatives of the board about the lack of senior level engagement. Despite these actions, the board has not improved its effectiveness in understanding the quality of help and support provided to children and families in Croydon.

100. There are improved strategic partnership arrangements, leading to better shared understanding and joint work. However, partnership working in frontline services needs strengthening. This is very apparent in the lack of multi-agency understanding of thresholds across the child's journey. Meaningful engagement and challenge from partners in key discussions and meetings aimed at protecting children, such as strategy discussions and core group meetings, are lacking. This means that children's plans do not benefit from full multi-agency involvement.

101. For children on the edge of care, the implementation of the PLO has been late in Croydon, but it is now beginning to have some impact. Similarly, the appointment of a new case progression manager is beginning to ensure more consistent court practice. However, while the local authority demonstrates an effective relationship with Cafcass, the relationship with the judiciary is poor. Despite very recent improvements, the judiciary expressed considerable concern about the quality and timeliness of legal representation in court. It highlighted a number of practice concerns, which included poor recognition of neglect, poor planning for children, resulting in significant delays, and a culture of crisis management in Croydon.

102. Croydon has taken action following the JTAI to strengthen performance information and this has resulted in improved performance management data. This includes a monthly dashboard, performance clinics and performance meetings, including a monthly safeguarding meeting chaired by the leader of the council. However, data is not collected in all areas to inform practice improvements, for example complaints from children and families. Despite weekly and daily monitoring of some priority areas of child protection processes, this monitoring does not translate into commensurate action that improves practice in key areas. Some managers do not understand performance data and, as a result, there are gaps in key areas of performance oversight, such as missing children. Performance management is therefore not informing practice improvement sufficiently.

103. The annual quality assurance framework covers a range of relevant activities. However, information is not routinely collated and analysed to aid understanding of inconsistent practice and outcomes. Auditing activity takes place regularly and inspectors noted that audit findings were accurate in 75% of cases seen. However, managers do not systematically follow up on agreed actions, and escalation processes are not routinely utilised by child protection chairs and IROs to alert senior managers to the impact of deficits in practice, for example delays in planning for permanence or insufficient progress in plans.

104. Improved commissioning arrangements at a strategic level ensure that commissioned services are informed by the needs of children in most cases. Commissioned services, underpinned by dedicated needs analysis, build on the information contained in the joint strategic needs assessment (JSNA). Partners recognise that further work is required to strengthen the JSNA and the Health and Wellbeing Board is considering this. The local authority has developed joint commissioning with the clinical commissioning group and together they have successfully commissioned a number of services that include a new CAMHS contract. However, not all contracts meet the needs of children. The advocacy contract, which began in January 2017, provides an issue-based service only and precludes children who are looked after and care leavers.

105. The joint approach to commissioning is demonstrated in framework contracts for placements. Placement stability for children looked after in foster care is strong and a high proportion of children live in family placements. However, a group of foster carers told inspectors that they do not feel valued and do not all receive the support that they need.

106. The lead member for children and young people, as the chair of the corporate parenting panel, actively engages with children and advocates on their behalf. Changes to the corporate parenting panel mean that all children across the borough can become involved in topic-based discussions. As a result, the panel has been effective in championing some issues for children and young people. For example, last year young people were part of a 'takeover' of the scrutiny committee, during which they explored housing issues for young people.

107. However, the panel is not sufficiently focused on poor performance and the practice priorities in the improvement plan. More work is also required to engage the Children in Care Council. A new draft engagement strategy is currently being debated and refined, which will begin to take these issues forward and further develop children's involvement in scrutiny and the cabinet. At the time of the inspection, Croydon was hosting a youth congress to debate young people's engagement, at which there were over 200 delegates. (Recommendation)

108. Strengthening the voice of the child is a stated key priority for all leaders in Croydon. However, this desire is not evident in most cases seen on this inspection. Inspectors consistently saw a lack of understanding of the lived experience of children, a lack of involvement of children in their plans and limited access to advocacy and independent visitors for children.

109. Dealing with complaints from children and families is an area that requires further development. A new corporate team has been set up and the first children and families quarterly report was recently presented to children's services senior managers. It contains only basic information; it lacks analysis and does not identify the sources of complaints. There is also no routine monitoring of complaints from children looked after. As a result, managers do not know how many children make complaints, nor their reasons for doing so. Further work is required to ensure that practitioners and managers have received training, and that a culture of feedback is embedded. (Recommendation)

110. Management oversight at all levels is weak. Supervision is ineffective in the majority of cases seen by inspectors. For some, there were long gaps in the frequency of supervision, and records show a lack of reflection and clarity about actions required in a significant number of cases. This leads to a lack of direction and purposeful work with children, and contributes to unnecessary drift and delay. Senior managers have not created good conditions in which social workers can flourish. A number of social workers told inspectors that they are not clear about what they need to do. (Recommendation)

111. Some social workers, in some teams, have high caseloads and very low morale. This is particularly true for social workers in the care planning units and for new social workers undertaking their assessed and supported year in employment (ASYE). The vast majority of ASYEs who spoke to inspectors said that they feel overwhelmed. They do not all have protected caseloads and therefore do not receive the support and supervision that they require to work effectively with children.

112. While workforce development is a priority for Croydon, this work is underdeveloped and, consequently, it has not affected turnover and vacancy rates. More work is therefore required to ensure that there is a more stable workforce, particularly for children in need and those on child protection plans. Work has been slow to target training and learning opportunities to those who need them, following findings from external reviews and practice weeks. As a result, action is required to ensure that social workers and managers have the skills they require to properly protect and care for children. (Recommendation)

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is inadequate

Executive summary

The CSCB is inadequate. It has not fully established effective arrangements for discharging its statutory functions. In particular, it does not understand the experiences of children and young people locally, and has failed to sufficiently monitor and evaluate the effectiveness of frontline practice.

While board members are aware of inadequate practice identified in previous multi-agency audits, SCRs and the findings from practice weeks, they do not provide effective challenge, or take sufficient timely action to address the poor practice and serious and widespread risks to vulnerable children in Croydon. There has been too great a focus on process that has led to insufficient understanding and prioritisation of required actions.

The board lacks direction and purpose, despite undertaking considerable activity, and it is unclear what difference this is making for children. The annual report and business plan are overly optimistic about progress, lack rigour and are not evidence based.

The early help strategy is insufficiently coordinated and implemented and the board has not ensured that pathways to early help services are well understood and applied. Ineffective action to address this fundamental deficit means that the board cannot be assured that children are receiving the right level of help at the right time.

The board leads the overall strategic approach to child sexual exploitation and children missing from home and care. While it is successfully raising awareness across a range of settings, poor scrutiny by the board means that it is not aware that basic child protection procedures for children at risk of sexual exploitation and those missing from home or care are not being followed.

Agreement for SCRs is in line with statutory guidance; learning is disseminated, but is not embedded in frontline practice. The board receives an appropriate range of reports about private fostering, the work of the designated officer and IROs. However, more rigour is required from board members to ensure that the information in these self-reports is triangulated.

There is national and international recognition for work in protecting children from female genital mutilation and for work in supporting unaccompanied asylum-seeking children in Croydon. There is significant engagement with the community and faith groups to raise awareness of specific issues facing children.

Recommendations

113. Ensure that the revised membership, remit and priorities of the board include effective processes that monitor and evaluate actions for their impact on outcomes for children.

114. Include the work of the previous child sexual exploitation and 'missing' sub-group in the Vulnerable Adolescent Committee to ensure effective connection between children at risk of child sexual exploitation, those who go missing, gang affiliation and 'county lines', and to achieve a consistent application of the board's procedures for these children.

115. Ensure that the multi-agency dataset contains sufficient information to improve quality assurance activity and to judge the effectiveness of services, particularly in relation to early help, children in need of help and protection and those in care.

116. Ensure full implementation of the early help strategy, including appropriate action to ensure shared understanding and consistent application of thresholds across the partnership.

117. Develop robust processes to routinely scrutinise, monitor and evaluate the effectiveness of frontline practice. This is to provide evidence of the board's focus on outcomes, demonstrating that it is making a difference to vulnerable local children.

Inspection findings – the Local Safeguarding Children Board

118. The CSCB is inadequate, as it has not fully established effective arrangements for discharging its statutory functions. In particular, it does not understand the experiences of children and young people locally, and has failed to sufficiently monitor and evaluate the effectiveness of frontline practice.

119. Formal arrangements are in place for the chair of the CSCB to have regular monthly meetings with the chief executive, the executive director of people and the lead member for children. However, these have not led to senior leaders fully understanding the serious and widespread risks to children identified during this inspection.

120. While the chair is a member of a number of strategic boards, in practice there is little evidence to demonstrate that strategic bodies hold each other to account, and that these arrangements are effective in safeguarding children in Croydon. Consequently, the partnership's response to safeguarding children is not assured.

121. The early help strategy is insufficiently coordinated and implemented and the board has not ensured that pathways to early help services are well understood or applied. Over a year ago, the JTAI identified that partners have insufficient understanding of thresholds and ineffective action taken by the partnership to address this fundamental deficit means that there are still no assurances that children are receiving the right level of help at the right time. (Recommendation)

122. Systems in place for monitoring and evaluating frontline practice are ineffective. Board members noted recurring themes in findings from their multi-agency audits, practice week and learning reviews. Minutes of meetings recorded comments by board members that partners were not working together as a 'collective' and that relationships were 'fractured'. The CSCB failed to recognise, monitor and systematically evaluate the seriousness of these findings. Insufficient challenge by the board in holding partners to account for these failures has resulted in too many children being left unprotected at the time of this review. (Recommendation)

123. Child sexual exploitation arrangements are coordinated and monitored through the child sexual exploitation and 'missing' sub-group and there are plans to extend the work of the group to include all exploited and vulnerable children. This group has successfully raised awareness across a range of settings that includes direct work in schools leading to earlier identification of children at risk and collaborative work with voluntary sector projects based in sexual health clinics. Despite this, inspectors found that too many practitioners do not follow the safeguarding board's basic procedures for assessing the needs of children at risk of sexual exploitation or those who go missing from home and care. Return home interviews and risk assessments are not routinely undertaken and, as a result, these children are not adequately protected from ongoing harm. (Recommendation)

124. Innovative projects led by the police, for example 'Operation Raptor', provide reliable analysis showing that the profile of children at risk in Croydon is largely one of small groups of peer-to-peer risk and gang-associated incidents. While data indicates that children at risk of sexual exploitation are not linked with 'county lines', the report shows that 'missing' children are. The analysis from 'Operation Raptor' shows that 60 children are involved in cross-county drug activity. This includes nine children looked after in Croydon and 15 from other local authorities. The partnership has not done enough to understand and address the poor practice in this area.

125. A review of the membership of the board took place in November 2016. However, there is too much focus on process, which has affected the ability of the board to know if outcomes for children have improved. The board still lacks direction and purpose and, while there is considerable activity, it is unclear what difference it is making for children. The board does not ask the right questions and board members are too accepting of self-reporting. The annual report states that the board achieved eight of the 10 priorities set out in its business plan. This analysis is overly optimistic and lacks rigour. It is not evidence based and does not accurately reflect the failure to safeguard children and young people in Croydon. (Recommendation)

126. An externally commissioned review of the board in January 2017 recommended that the voice of the child should underpin the work of the board. The chair has persistently requested that partners evidence the impact of their agency's work in protecting children; they have not complied with this request. This questions the authority of the chair and whether agencies fully understand and know if children who have contact with their individual agencies receive help proportionate to their presenting risks and needs. Recent changes to the section 11 audit are aimed at making this more robust.

127. Recent action has strengthened the multi-agency performance management information. This is a positive development as it includes the new monthly dashboard and shared database. More work is essential in order to align the top-line data with qualitative information, as currently there is insufficient impact on the persistent shortfalls that inspectors found in services for children who need help and protection and for those in care. (Recommendation)

128. SCRs are agreed in line with statutory guidance and there have been four commissioned in 2016–17; the associated recommendations are appropriately monitored and reported to the board. Learning from SCRs, while disseminated to all agencies, is not embedded in frontline practice. While there is a comprehensive learning and development programme that provides opportunities to engage effectively with partners, more work is needed to evaluate and evidence the impact of training in all agencies.

129. The board has received an appropriate range of reports regarding private fostering and the work of the designated officer and IROs. There is more rigour required by board members to ensure that the information in these self-reports is triangulated.

130. The child death overview panel (CDOP) identifies the learning arising from child deaths effectively. The annual report is thorough and analytical and all deaths are reviewed within a year of the death. The CDOP has taken action at local and regional levels to drive changes. The chair participates in pan-London workshops coordinated by the Healthy London Partnership CDOP, during which good practice is shared and learning opportunities are maximised in an effort to reduce the risk of child deaths in the future. Rapid response meetings are appropriately prioritised and effective.

131. All partner agencies have worked well together to achieve better outcomes for specific groups of children. For example, there is national and international recognition for work in protecting children from female genital mutilation and for work in supporting unaccompanied asylum-seeking children in Croydon. In addition, meaningful engagement with the community and faith groups has raised awareness of specific issues facing children who are sexually exploited or affected by gangs, or who go missing from home and care. Improved collaboration and joint work with social housing providers and a recent initiative with a local premier league football club ensure understanding and prioritisation of children and their families.

Information about this inspection

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people whom 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 eight of Her Majesty's Inspectors (HMI) from Ofsted.

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Appendix 2

Monitoring and re-inspection of local authority children's services judged inadequate

Inspectors' handbook

This guidance describes the main activities that social care Her Majesty's Inspectors (HMI) undertake in local authorities that have children's services judged to be inadequate.

Section one outlines our arrangements for monitoring the progress of local authorities with inadequate children's services.

Section two outlines our arrangements for re-inspecting inadequate local authorities once the period of monitoring has ended.

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Contents

Section one: monitoring visits

1. The Office for Standards in Education, Children's Services and Skills (Ofsted) believes that all children who use children's social care services are entitled to services that are good or better. Where local authority children's services are judged to be inadequate, Ofsted will carry out monitoring visits and report on the progress made by the local authority, to support them to improve further.

2. This guidance is for Ofsted inspectors. Local authorities and professionals working with children and young people and their families can use the guidance to see how the monitoring visits will be conducted.

3. Where local authority children's services are judged inadequate, Ofsted will carry out a programme of monitoring activities, including quarterly monitoring visits, to report on the progress made by local authorities. Where a local authority is not prepared to agree the programme of quarterly monitoring visits, we will refer the authority to the Secretary of State who is likely to intervene and direct Ofsted to undertake visits under section 118(2) of the Education and Inspections Act 2006.

4. All local authorities judged to be inadequate will receive an action planning visit, a programme of quarterly monitoring visits and a re-inspection.[1]

Notification of the inspection judgement and the future monitoring activity

5. If the local authority is judged to be inadequate for their children's services or where areas for priority action are identified that suggest children are at risk of significant harm, the lead inspector will:

   - inform the relevant regional director and senior HMI (SHMI) of the provisional judgement
   - alert the director of children's services (DCS) that, the local authority:
     - should arrange an action planning visit between 25 and 35 days after receiving their report and that an Ofsted inspector will attend
     - will receive quarterly monitoring visits from Ofsted to evaluate the progress made against the recommendations since the inspection and to check that there is no decline in other areas.

6. At the inspection feedback meeting, the lead inspector will remind the local authority that they must produce a written statement of proposed action (the action plan) and submit this to the Secretary of State and HMCI within 70

[1] More information on re-inspections is in section two of this guidance.

working days of the receipt of the inspection report.[2]

7. The letter that accompanies the pre-publication copy of the inspection report will confirm the submission deadline for the action plan – within 70 working days of receiving that report. A copy of this letter will be sent to the lead inspector and the responsible regional SHMI.

Action planning visit

8. Ofsted will visit the local authority to ensure the local authority has a sufficient understanding of the recommendations to plan appropriately following the inspection judgements. The purpose of the visit is to:

   - clarify the roles, responsibilities and activities of Ofsted and the DfE
   - give local authorities and their partners a comprehensive understanding of the inspection judgements to enable the local authority to fulfil its statutory responsibility to develop the post-inspection action plan
   - explain the purpose and significance of recommendations in the context of the three key judgements
   - set out the implications for statutory partners, including the local safeguarding children board
   - support the local authority to develop an action plan that links clearly with the recommendations from the inspection
   - consider the draft action plan (if available)
   - confirm the date of the first monitoring visit and establish the pattern of future monitoring activity
   - agree the specific focus of the first monitoring visit and (where possible) any subsequent monitoring visits.

9. Once the local authority has received their report, the regional director will write to the DCS confirming the action planning visit (see letter template at Annex A). This letter will be copied to the lead inspector from the single inspection, the inspector who will lead the monitoring visits (if already identified), the regional SHMI, the Ofsted national director (social care) and the DfE inspections and interventions team.

10. The visit should take place between 25 and 35 working days after the local authority has received its inspection report.

[2] This responsibility is set out in the Education and Inspections Act 2006 (Inspection of Local Authorities) Regulations 2007, Paragraph 3.

11. The visit is attended by:

    - the lead inspector of the local authority's single inspection (or another member of the inspection team if the lead inspector is unavailable)
    - a senior HMI based in the local authority's region
    - participants selected by the local authority.

12. It is for the DCS to determine who should attend the action planning visit, though the DCS may wish to discuss this with the lead inspector to ensure that attendees are appropriate to the recommendations in the report. The attendees will usually include senior managers of the local authority children's services and other key partners. As the visit is concerned with the work of children's services professionals, elected councillors would not normally attend.

13. The lead inspector should ask scheduling colleagues to add one day for preparation and one day for the visit in their schedule. The lead inspector should also notify the inspection and management support team supervisor of the date of the visit.

14. The SHMI and lead inspector will discuss the agenda for the action planning visit with the DCS before the event. This gives the DCS an opportunity to influence any specific areas that they want the visit to focus on. The lead inspector will circulate the final agenda five working days before the visit. An example agenda is at Annex B.

15. If the local authority has an early draft of their action plan, the DCS should share this with the lead inspector before the action planning visit to assist planning. Early drafts of action plans are accepted as 'work in progress' and will not be formally reviewed by the inspector.

16. It is for the SHMI to introduce the action planning visit setting out its purpose. The role of the lead inspector and the SHMI is to present the priorities and key recommendations of the inspection report in more detail and enter into formal discussion with the participants so that they can be fully aware of:

    - the evidence that supports the recommendations
    - the priorities for action
    - the detail that underpins any areas about which the local authority remains uncertain.

17. The lead inspector's presentation should not replicate inspection feedback. It should be concise and target the key issues that need to be discussed. It should inform debate with and between participants so that the local authority can use the material to develop its action plan.

Recording

18. The lead inspector should keep a record of the outcome of the discussions (Annex C), which will be retained by Ofsted on its internal systems. The SHMI should also send it to the DCS, copied to the regional director and the Ofsted national director, social care.

Action plan

19. Local authorities have a maximum of 70 working days from when they receive the inspection report to submit a 'written statement of action' to the Secretary of State and HMCI. This is required irrespective of the inspection judgement.

20. The lead inspector will review the action plan as soon as possible after receipt to check that it reflects the recommendations contained in the inspection report. Ofsted is not responsible for 'signing off' or endorsing the action plan – this is the responsibility of the DCS. Here, Ofsted's role is to advise the DCS about whether the action plan reflects the recommendations in the inspection report.

21. Ofsted's regional director will write to the DCS confirming whether the action plan reflects the inspection findings. If Ofsted considers that the action plan does not properly reflect or address the recommendations set out in the inspection report, the lead inspector and/or SHMI should discuss this with the DCS to ensure that the recommendations have been fully understood. Where this is not resolved, the regional director will write to the DCS setting out the area(s) of difference and the reasons. Annexes D and E provide templates for this correspondence. The lead inspector will keep the national director, social care informed.

22. The lead inspector will inform the interventions team at the DfE of the outcome of this process. If the differences are not resolved, the Secretary of State will be asked to consider what action (if any) the DfE wishes to take in response.

Monitoring visits

23. At the action planning visit, the SHMI, HMI and DCS will agree arrangements for the quarterly monitoring visits. The monitoring visits may not be equally spaced throughout the year. The first monitoring visit will usually be within four weeks of the submission deadline for the local authority's action plan (which is within 70 days of their receipt of the inspection report). The lead monitoring inspector will confirm the dates of the visits in advance.

24. Usually two HMI will undertake each visit. They may be accompanied by an additional seconded inspector. They will work closely with a senior children's service colleague nominated by the local authority to help coordinate the monitoring visits. Each visit will usually last for two days. Wherever possible, the same HMI will lead all these monitoring visits.

25. Monitoring activity should relate to the key weaknesses and recommendations in the inspection report. The role of the HMI conducting the quarterly visits is to monitor and report on the local authority's progress since the last inspection. The HMI will also check that performance in the other areas has not declined since the inspection. Where new concerns have emerged since the last inspection, we are likely to look at these as part of monitoring.

Pre-visit preparation

26. The lead monitoring inspector will confirm the arrangements for each monitoring visit in advance with the local authority. Once the date of a visit is confirmed, the lead inspector will ask the local authority to provide the latest available child-level data required to carry out the agreed monitoring work. This request will usually be two weeks before the monitoring visit. When providing the data, the local authority should indicate any cases that they have audited since the last monitoring visit.

27. The HMI may ask the local authority to audit cases but in most instances the HMI will request information about up to six cases that have already been audited by the local authority. The local authority will be asked to return the completed audits at least three working days before the monitoring visit.

28. The local authority should provide any information requested using secure processes. Inspectors will provide details for accessing a secure online site that local agencies can choose to use for this purpose. This site has been risk assessed by Ofsted against the Government's cloud security principles[3] to handle sensitive personal data.

29. Ofsted will only request data that is necessary to inform the activity specific to that monitoring visit. Any requests will be based on an extract of the data that is currently required for the inspections of services for children in need of help and protection, children looked after and care leavers – the single inspection.

30. The HMI and/or SHMI may, with the agreement of the DCS, attend the local authority's improvement board meetings as an observer, or other related meetings, for example with DfE officials.

Monitoring visit activity

31. The lead inspector and DCS will agree a timetable for the onsite activity.

32. Activity on any monitoring visit, including tracking and sampling children's cases, will follow the methodology in the handbook for the single inspection.

[3] 'Summary of cloud security principles', CESG and Cabinet Office, August 2014; www.gov.uk/government/publications/cloud-service-security-principles

33. On-site activity will usually consist of tracking the experience of a maximum of six children and young people. The criteria used to select cases will be agreed with the local authority before each monitoring visit.

34. Inspections will track or sample the cases audited by the local authority to evaluate how effective the local authority's auditing systems are and this will inform their evaluation of its progress and performance.

35. The tracking of children's experiences will be complemented by some case sampling activity. Where sampling is a more appropriate method to gather evidence in the particular focus of the inspection, the number of cases selected for tracking may be reduced. Any sampling activity should be proportionate to the nature of the service and/or area of practice that inspectors are evaluating. Inspectors will usually only sample cases from the previous three months.

36. Where the HMI identifies a cause for concern about the help, protection or care provided to a child/children, these must be brought to the attention of the DCS.

37. HMI will record the evidence collected and conclusions drawn during each monitoring visit. Inspectors must record the case numbers of tracked and sampled cases so that this can be cross-referenced in future visits.

38. At the end of each visit, the lead inspector will summarise and feedback the inspection findings to the DCS, chief executive and commissioner (where one is appointed). The Ofsted regional director and/or quality assurance (QA) manager may be present for the feedback meeting. If the authority and inspectors disagree on the findings, this must be recorded.

39. The areas to consider at the next monitoring visit will be agreed with the local authority at the feedback. Where the date of the next monitoring visit is known, the lead inspector will confirm the milestones by when the local authority should provide information, including whether the local authority will be required to specifically audit any cases.

Reporting of monitoring visits

40. The HMI will write a brief report about their findings and, in particular, their evaluation of the local authority's progress. The local authority will be given an opportunity to review the factual accuracy of the report before it is finalised.

41. Ofsted will not publish the report relating to the first monitoring visit. Ofsted will usually publish the report of each subsequent monitoring visit.

Timeline

42. A timeline showing the monitoring visit arrangements is shown below.

Working day	Activity
Two weeks before visit	Lead inspector requests child-level data. Local authority provides this data by the end of that week, indicating which cases they have audited.
Eight days before the visit	Lead inspector notifies local authority of audited cases to submit.
At least three days before the visit	Local authority submits audited case files (before the inspectors' preparation days).
Two days before onsite activity	Preparation by inspectors.
Days 1 and 2	Inspectors onsite
Day 3	Inspection team writes report
Day 4	Lead inspector and QA manager quality assure the report
Days 5 and 6 (am)	Regional director reviews the report
Days 6 (pm) and 7	National Director, Social Care (or Deputy director, Social Care) reviews the report
Day 8	Lead inspector/QA manager revises the report
Day 9	Inspection support team reviews the report
Day 10	Lead inspector/QA manager revises the report
Day 11 (by 4pm)	Inspection support sends draft report to local authority for factual accuracy check
Day 11 (4pm) – Day 15 (9.30am)	Local authority checks factual accuracy of the report
Day 15 (by 9.30am)	DCS provides factual accuracy comments on the report
Day 15	Lead inspector and QA manager review factual accuracy comments and report
Days 16–17 (am)	QA manager/Regional director clears report
Day 18	Inspection support team proof reads the report
Days 19–20	QA manager/Regional director clears final report
Day 21	Inspection support sends pre-publication report to DCS
Day 23	Report published

Quality assurance

43. All inspectors are responsible for the quality of the monitoring visit and are accountable for the quality of the report.

44. Each monitoring visit will have a QA manager, usually the regional SHMI. The QA manager will not usually be onsite during the visit.

45. The role of the QA manager is to have oversight of the evidence base to provide assurance that the findings and evaluation of progress are robust. They will provide support and guidance to the HMI and oversee the final report to publication.

46. All inspectors are expected to quality assure their own and other inspectors' work during visits. The lead inspector has overall responsibility for ensuring that all the evidence gathered is robust, reliable and secure.

Complaints

47. Ofsted aims to carry out all of its work to a high standard but recognises that, occasionally, concerns may arise about its actions or the conduct of its staff. We expect that in the first instance, all concerns about our work will be raised, wherever possible, as soon as they arise and directly with the individual inspectors involved. If the complainant is dissatisfied with the inspector's response, they should be made aware of Ofsted's complaints procedure, available at: www.gov.uk/government/organisations/ofsted/about/complaints-procedure.

Section two: re-inspection of inadequate local authorities

48. This section of the guidance outlines arrangements for re-inspections when Ofsted decides to undertake a post-monitoring single inspection rather than a full single inspection. This guidance must be read in conjunction with the single inspection framework (SIF) and associated inspector handbook.[4] Unless otherwise stated within this section, inspectors will follow the single inspection framework and inspector handbook.

49. Ofsted will usually re-inspect a local authority judged inadequate at its last inspection within two years of it submitting its action plan. The deadline for the local authority to submit its action plan is within 70 working days of receiving its pre-publication inspection report. A re-inspection will not usually take place until there have been at least four quarterly monitoring visits. This is because our evidence shows it is unlikely a local authority will be able to demonstrate sufficient improvement to alter its inspection outcome in less than a year.

50. Ofsted will tell the local authority when they decide that a re-inspection is the appropriate next step. At this point no further monitoring visits will be scheduled. Ofsted will not tell the local authority when that re-inspection will take place. The timing of the inspection is not within a prescribed timeframe but will be in the coming months. Ofsted will want to see that the improvements identified in the monitoring visits have been maintained.

51. Local authorities found to be inadequate across all or most areas will receive a full repeat single inspection. For local authorities in which inadequacy is less widespread – for example, a local authority that is inadequate in either, help and protection or children looked after – Ofsted may undertake a 'post-monitoring single inspection' instead.

52. The scope of the post-monitoring single inspection is the same as the single inspection and inspectors will make the same judgements. Inspectors will be on site for less time than in a full inspection under the SIF. The shorter fieldwork is possible because of the substantial body of evidence gathered by Ofsted on its quarterly monitoring visits.[5]

53. Ofsted re-inspects local authorities under section 136 of the Education and Inspections Act 2006.

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[4] 'Single inspection framework: children in need of help and protection, children looked after and care leavers'; Ofsted 2013; www.gov.uk/government/publications/inspecting-local-authority-childrens-services-framework and 'Inspection handbook: children in need of help and protection, children looked after and care leavers'; Ofsted 2013; www.gov.uk/government/publications/inspecting-services-for-children-in-need-of-help-and-protection-children-looked-after-and-care-leavers-and-reviews-of-local-safeguarding-children-boa--2.

[5] See section one of this guidance for more information on monitoring visits.

Decision to undertake a post-monitoring single inspection

54. The decision to undertake a post-monitoring single inspection lies with the Ofsted regional leadership team. The decision will be informed by:

- information gathered during the quarterly monitoring visits
- the local authority's evaluation of its improvement journey and performance, including whether they consider they are ready for re-inspection
- the view of the Department for Education
- performance data
- other regional intelligence, for example inspection outcomes of regulated settings run by the local authority.

Decision making process for conduction a post-monitoring single inspection

Deployment for post-monitoring single inspection

55. The inspection team will usually be four social care HMI. The team size may change to reflect circumstances, size and complexity of the inspection or local authority. The inspection team will include HMI who undertook monitoring visits in the local authority. This will usually be the HMI who led the monitoring visits.

56. A senior analytical officer from Ofsted may be on site for up to two days in week one and one day in week two. When they are not on site, they will support the inspection remotely.

Pre-inspection

57. The lead inspector will have two planning days, up to three weeks before the inspection fieldwork. These two days will be for the lead inspector to identify areas where there is already substantial, up-to-date evidence from the monitoring visits that will only require final triangulation during the inspection. The days will also be used to determine any lines of enquiry in addition to the areas of weakness identified at the last inspection. This will enable the inspection team to be more targeted in its evaluations of practice, leadership and management.

58. Data analysts will provide a pre-inspection briefing (PIB). The PIB will focus on:

- relevant data/information published by the local authority
- national data trends and comparisons
- data and trends from monitoring visits
- other intelligence, for example serious incident notifications and whistleblowing
- links to significant and relevant published documents, for example serious case reviews and other relevant inspection reports

59. The lead will determine which documentation from the single inspection framework (SIF) Annex A is required from the local authority at the start of the inspection.

Notice period

60. The lead inspector will notify the director of children's services two days before they arrive on site. This will usually be the Thursday before fieldwork.

Inspection activity

61. The inspection activity on a post-monitoring single inspection will mirror the full single inspection. However, we will not ask the local authority to audit a sample of children's cases for the inspection. Inspectors will ask for a list of children's cases that the local authority has audited in the past three months. Inspectors will track and sample some of these children's cases using the guidance and recording tools in the single inspection handbook. They will also sample some randomly identified children's cases.

62. All inspectors' evaluations of practice, leadership and management will be benchmarked against the grade descriptors within the single inspection framework. Inspectors' evaluations will be made based on evidence gathered during the inspection, but inspectors will also rely on the substantial evidence base from recent monitoring visits to help develop robust lines of enquiry and to triangulate their findings. Where findings from monitoring visits indicate strong performance, inspectors will only sample sufficient cases to satisfy themselves that this performance has been maintained or improved.

Inspection fieldwork – indicative timeline

Day	Day of week	Activity
Two days – up to three weeks before		Lead inspector planning days
-2	Thursday	Local authority notified of the inspection (AM). Lead inspector requests information to support the inspection.

Day	Day of week	Activity
1	Monday	All inspectors travel (PM) lead inspector on site PM to set up the inspection.
2 – 4	Tuesday – Thursday	Onsite evidence gathering
5	Friday	Case tracking meeting (AM). QAM on site. Travel (PM)
6	Monday	Travel (PM)
7 – 8	Tuesday – Wednesday	Onsite evidence gathering
9	Thursday	Mop up activity (AM) Provisional judgement meeting (PM) QAM on site
10	Friday	Confirm judgements. Feedback (late AM). Travel (PM) QAM on site

Communicating with the director of children's services

63. The lead inspector will carry out one keeping in touch (KIT) meeting per day, including the final day of week one. There will not be any further feedback at the end of week one. Feedback arrangements on the final day of inspection will mirror those for a full single inspection.

The post-monitoring single inspection report

64. The inspection report will include:

- a one-page executive summary
- up to two pages per key judgement summarising the key strengths and weaknesses
- a one-page summary of the graded judgements
- recommendations for improvement.

65. A post-monitoring single inspection report should not usually exceed 12 pages in total.

After the inspection

66. Arrangements to sign off and check the factual accuracy of the report will mirror the single inspection handbook.

67. If the inspection determines that the local authority remains inadequate, the monitoring process in section one of this guidance will start again. In the event that the Secretary of State appoints a Children's Services Commissioner or begins the process of removing service control from the local authority, Ofsted will consult with DfE about next steps.

Annex A. Draft letter to DCS: action planning visit

The regional director should send this letter to the DCS and copy it to Ofsted's national director, social care as soon as the SIF inspection report is published.

Dear (director of children's services)

Inspection of (name of local authority) children's services: action planning visit

As part of Ofsted's response to local authorities judged to be inadequate, we now deliver an action planning visit. This visit is to support you and your senior leaders in creating an action plan that reflects the findings of our inspection support. The improvement board chair and your link person from the Department for Education (DfE)'s inspections and intervention team, as well as relevant colleagues from partner agencies and the local safeguarding children board should attend.

We normally expect the visit to take place between 25 and 35 working days of you receiving the inspection report. In your case, this means between (enter dates). (If the lead HMI/SHMI has preferred dates, enter them here.) As this event aims to support your action planning, the attendance list is for you to agree with the lead inspector. Our experience suggests that it should be limited to those who will have a direct contribution to make to improvement in your area and who have the authority to do so.

The purpose of the visit is to enable the lead inspector and senior HMI to present the key priorities of the inspection report in more detail before entering into informed discussion with you and your delegates to:

- ensure that you are fully aware of the evidence that supports our recommendations
- clarify any areas about which you are still not certain.

We are confident that it will be helpful and directly relevant to the work that you are undertaking to finalise your action plan.

I would be grateful if you could confirm the options for dates that you can accommodate and your proposed list of attendees. I look forward to hearing from you at your earliest convenience.

Yours sincerely

(Name of regional director)

cc SHMI, HMI and national director, social care, DfE at SocialCare.INSPECTION-IMPROVEMENT@education.gsi.gov.uk

Annex B. Draft agenda for action planning visit

Note. The programme detailed below is meant only as a suggested guide to indicate the topics that should be considered for the action planning visit's discussions. In liaison with the local authority concerned, the programme should be tailored to the particular circumstances as necessary.

Welcome and introductions (SHMI and DCS)

Understanding the inspection findings and judgements

- group discussion led by lead inspector from the single inspection.

What has happened since the inspection?

- group discussion about the actions the local authority has taken so far.

Understanding the performance challenges

- understand the inspection judgement and identify barriers to change
- begin to articulate the priorities for change and the capacity needed to make it happen.

Identifying improvement priorities

- identify evidence measures for change and leadership responsibilities
- agree initial timescales, improvement strategy (including relationship with Ofsted HMI/SHMI and the improvement board work).

Summary of improvement planning and next steps

- review the expectations in respect of next steps, the preparation of the written response to the inspection in the form of an action plan and timescales for submission.

Annex C. Record of action planning visit

>Insert name of local authority<

1. List of attendees:

2. Details of discussion:
Should be compiled at the time by the SHMI. Any areas of continuing disagreement between the original inspection findings and recommendations should be noted.

3. Details of formal planning:
Action planning visit discussions may lead to agreements about how recommendations are to be addressed in the action plan. However, Ofsted should not prescribe how this is to be done. It is important that any agreed variation from the report's recommendations are recorded together with the reasons.

Agreed and signed by Ofsted HMI and SHMI:

Date of record:

Annex D. Letter to DCS following receipt of the post-inspection action plan

(This letter will be sent by the regional director and copied to the national director, social care. The letter should also be copied to the link person in DfE's inspections and intervention team.)

Dear (name of DCS)

Inspection of (name of local authority) children's services: action plan

Thank you for sending me a copy of your local authority's action plan dated (enter date). The plan satisfactorily reflects the recommendations of the inspection report and incorporates the outcome of discussions at the action planning visit that took place on (enter date).

As you know, Ofsted will track the progress of your action plan as we proceed through our monitoring visits and we shall discuss its impact on children and young people at key stages throughout the process.

Yours sincerely

(Name of regional director)

cc SHMI, HMI and the national director, social care and the link person in the DfE's inspections and intervention team

Annex E. Letter to DCS after receiving a post-inspection action plan that does not reflect the inspection findings

(This letter will be sent by the regional director and copied to the national director, social care and to the DfE inspections and interventions team.)

Dear (name of DCS)

Inspection of (name of local authority) children's services: action plan

Thank you for sending me a copy of your local authority's action plan dated (enter date). I write to advise you that the plan does not reflect the recommendations of the inspection report and fails to incorporate the outcome of discussions at the action planning visit that took place on (enter date).

(Draft paragraph to clearly but succinctly set out the areas of disagreement and the potential impact if they are not addressed)

I have asked the lead inspector (enter name) to have a further discussion with you as soon as possible to establish whether it is possible to resolve our different views. I shall look forward in due course to hearing about the outcome of this discussion. I will be grateful to receive a copy of the action plan if any amendment is made following this discussion. On receipt, I will write to you again.

Yours sincerely

(Name of regional director)

cc SHMI, HMI and the national director, social care and DfE inspections and interventions team.

Annex F. inspection notification email

Email to notify Director of Children's Services of the start of the inspection

Dear (insert name of Director of Children's Services)

Re-inspection of local authority children's services judged inadequate – (insert name of council)

This email is to inform you that I will arrive onsite on (insert date) to begin a re-inspection of services for children in need of help and protection, children looked after and care leavers. The rest of the inspection team will arrive onsite the following morning. The inspection will take place over a two-week period.

Week One	Week Two
Lead inspector on site Monday afternoon to set-up the inspection. Full inspection team on site Tuesday to Friday (**4 days**)	Full inspection team on site Tuesday to Friday (**4 days**)

I have spoken to (insert name and title of manager or 'to you') to inform him/her/you that the inspection will commence in line with the guidance published on our website.

We will be tracking cases, which will involve visiting offices to talk to staff, reading files and considering and observing front-line practice. We will identify cases to track from cases you have audited in the last three months. This will require the arrangements to be made expediently and I will talk to you how best to achieve this.

To help identify cases to track and sample, I will need lists of children and young people who are within the scope of the inspection and any meetings that will take place during the inspection. When compiling this information please refer to Annex A of the framework and evaluation schedule and the supplementary guidance.

Unless otherwise stated in the re-inspection guidance, inspectors will follow the single inspection framework and inspector handbook. Please see the links below for the relevenat documents. I will discuss the specific arrangements for your inspection with you before the full inspection team arrives onsite.

Monitoring and re-inspecting local authority children's services judged inadequate: www.gov.uk/government/publications/monitoring-local-authority-childrens-services-judged-inadequate-guidance-for-inspectors

Framework and evaluation schedule: https://www.gov.uk/government/publications/inspecting-local-authority-childrens-services-framework

Inspection handbook: www.gov.uk/government/publications/inspecting-services-for-children-in-need-of-help-and-protection-children-looked-after-and-care-leavers-and-reviews-of-local-safeguarding-children-boa--2

An online portal has been established to receive all Annex A information. Details for uploading information to this portal are in a guidance note appended to this letter.

All inspections are subject to a quality assurance process undertaken by a named quality assurance manager. If there are any issues the inspection team cannot resolve, you may wish to discuss these in the first instance with the manager for this inspection. This person is (insert name) and can be contacted on (insert number/email).

Summary of changes

This section outlines additions to guidance or changes to the methodology. This does not include corrections or changes made to improve clarity**.**

Changes made in May 2017

- More flexibility in the timing of quarterly monitoring visits.
- Amended guidance about sampling cases on a monitoring visit to ensure inspection activity is proportionate.
- Added information about the period between monitoring visits stopping and a re-inspection taking place.
- Introduced two days' notice for a post-monitoring SIF.
- Additional guidance on how the findings from monitoring visits inform activity at the re-inspection.
- The indicative timeline for a post-monitoring SIF has been simplified.

Changes made in August 2016

- Amendments to the report writing and quality assurance timeline for monitoring visits.
- Section two (re-inspection of inadequate local authorities) added to this guidance.

The Office for Standards in Education, Children's Services and Skills (Ofsted) regulates and inspects to achieve excellence in the care of children and young people, and in education and skills for learners of all ages. It regulates and inspects childcare and children's social care, and inspects the Children and Family Court Advisory and Support Service (Cafcass), schools, colleges, initial teacher training, further education and skills, adult and community learning, and education and training in prisons and other secure establishments. It assesses council children's services, and inspects services for looked after children, safeguarding and child protection.

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Department for Education

Appendix 3

Putting children first

Delivering our vision for excellent children's social care

July 2016

Contents

Ministerial foreword

Social services are the backstop of our society – offering help to families in need, and intervening where things go wrong. Yet children's social care is not a service that the majority of children and families ever have to draw on. For most families, the support network provided by relatives, friends, communities, schools and health services will enable them to provide their children with a safe, stable and nurturing home. However, there is a small but important group of children – our most vulnerable – who need more intensive support to have the stable foundation that others take for granted.

These children face challenges which most of us can only imagine. They may have disabilities, or have faced abuse and neglect. They may have been let down time and again by the people who are supposed to love and protect them. They may be being exploited by perpetrators preying on their vulnerability.

The horrors of the serious cases we all know about – Daniel Pelka, Hamzah Khan, Ellie Butler, the children exploited so terribly in Rotherham – demonstrate just how heartbreaking the consequences can be when we fail to protect our children.

But there are thousands more stories of children whose lives are transformed by social workers, foster carers, residential care staff or adopters. These people epitomise the compassion and deep desire in our society to help others, without which we, and our children, would be so much the poorer.

Over the last six years, working with local government, we have made real progress towards achieving more for the children and families we serve. We have made wide reaching reforms to the adoption system, to special educational needs and to the support provided to children in care. We have invested in over 50 innovation projects, testing out new approaches to children's social care. We have maintained our strong commitment to short breaks for disabled children and their families. We have introduced 'Staying Put', enabling young people to stay in their foster home to age 21 if they want to. We have provided over £100 million via the Pupil Premium Plus to help looked after children get ahead in school.

But we will not stop there. We are determined to bring about the widest reaching reforms to children's social care and social work in a generation. Earlier this year, we set out our vision for the children's social care system. We were very clear that we want a system

staffed and led by the best trained professionals; dynamic and free to innovate in the interests of children; delivered through a more diverse range of social care organisations; with less bureaucracy; smarter checks and balances designed to hold the system to account in the right ways; and new ways to intervene where services fail.

Today we are delighted to be publishing the government's strategy to achieve that transformation: our plan for 'Putting Children First'. This plan involves fundamental reform of each of the three pillars on which the children's social care system stands:

- first, **people and leadership** – bringing the best into the profession and giving them the right knowledge and skills for the challenging but hugely rewarding work ahead, and developing leaders equipped to nurture practice excellence
- second, **practice and systems** – creating the right environment for excellent practice and innovation to flourish, learning from the very best practice, and learning from when things go wrong
- third, **governance and accountability** – making sure that what we are doing is working, and developing innovative new organisational models with the potential to radically improve services

We need a system that works for every child – whether that be a child on a child protection plan whose parents are being supported to provide them with the kind of safe and stable home environment they need; a child moving towards a loving adopted home; a disabled child who needs help from social workers to live their life to the full; or a young person leaving care who needs the continued support and guidance that other young people receive from their parents. We need to get it right for every single one of these children, and that is what our plan for 'Putting Children First' is designed to achieve.

In a modern, one nation, Britain we have to strive for excellence in children's services, because as a fair and decent people, we believe that every child, no matter what their circumstances, should be afforded the best possible start in life. The kind of start that not only allows them to become successful adults, but also gives them the happy childhood that we want for all our children. We should be judged by how we treat the most vulnerable in our society, and that means putting our most vulnerable children first.

Rt Hon Nicky Morgan MP
Secretary of State for Education

Edward Timpson MP
Minister of State for Children and Families

Letter from the Chief Social Worker for Children and Families

Dear colleagues,

Today the government has published 'Putting Children First – Delivering our vision for excellent children's social care'. This signifies an historic step change for how we will work with children and their families in the future. It's important you read it and in discussion within your teams and organisations reflect on what it might mean for you, but critically what it will mean for the children and families with whom you work. Great opportunity to really change things for the better is within our reach. We must maximize this chance to radically improve the child protection and care system for children and their families.

Without doubt social workers must be trusted to get on and do the job they came into the profession to do. We must be enabled to use our professional judgment in flexible and creative ways, rather than having to follow a procedural path or series of legal rules, far too automated to match the social complexity of the lives of the children and families with whom we work. We also need to work within the right cultural context which supports a practice system sophisticated enough to meet that complexity. Organisations need practice focused leaders with high ambition for what we can achieve for children and families; practice leaders who firstly respect the need for sufficient time to undertake direct work with children and families which really helps and protects the most vulnerable, and secondly provide the necessary support and resources to do so. For many overstretched social workers that might sound a little like nirvana. But it isn't.

The undeniable reality is that in every single authority in England there are great social workers doing great social work, even where caseloads are high, supervision is infrequent, resources are reducing and there is little professional development. For some social workers, however, it's not such a daily battle. For there is a small but growing vanguard of children's social care organisations that are doing things differently – organisations where practice leadership is very strong, workloads are manageable, supervision is frequent, supportive and reflective and learning and development has become centre stage. In some organisations this is now starting to translate into fewer children coming into the care system through the provision of effective family support, the

safety and long term stability of children in the care system is getting better, and new ways of working with young people are providing properly supported independence.

We need to keep on building the critical mass of children's social care services that are getting it right for children and families. 'Putting Children First' sets out how government is going to help make this ambition a reality so that even in high performing services, outcomes for children and families are even better. Social workers – as practitioners, practice supervisors and practice leaders – have a most critical role to play alongside their multi-disciplinary colleagues, and the many parents and carers who have the *most* important role in children's lives.

'Putting Children First' is the gateway to the kind of practice social workers want to be doing every day. Probably the single most refreshing thing about 'Putting Children First' is its central recognition that relationships and long term social connection is the cornerstone to child and family welfare. This of course goes to the core of social work. It is why social work is such a pivotal player in the public service landscape and why social work is important to government. The fantastic and inspiring Innovation Programme, our radical Partners in Practice Programme, the new power to innovate, new opportunities for post qualification CPD and specialist accreditation under a dedicated new body for social work as one profession, a new What Work's Centre to get research into the heart of practice, are just some of the motivating changes in which government will invest. Some of you might have to suspend disbelief to become part of this progressive movement of change, and I urge you to do so. Don't let others interpret this opportunity for you and don't let it pass you by.

It has been a pleasure to meet and speak with so many of you and to hear your views to date. I look forward, very much, to continuing to meet and discuss with you this exciting agenda, as I continue visiting children's social care services across the country.

Isabelle Trowler
Chief Social Worker for Children and Families

Chapter 1: Our ambition for children, young people and their families

Putting children first

1. By putting children first, excellent children's social care can transform the life chances of our most vulnerable children and families. It can offer every child who has had a difficult start the promise of a brighter future, with every prospect of success.

2. Strengthening families is central to that aim. Children who grow up with safe, stable and nurturing relationships form stronger friendships, develop greater resilience, achieve more in school and are more likely to build successful careers and have positive relationships throughout their lives. The right support gives children independence, choice and control as they enter adulthood.

3. The fundamental purpose of children's social care is to make sure that our most vulnerable children – those who have been abused and neglected, or face other significant challenges such as a disability – can have a safe, dependable foundation from which to grow and flourish. This is achieved by supporting parents to provide the best possible care for their children or, where this is not possible, by giving them a stable and nurturing alternative home. It is only a small proportion of the nation's children who will need this support – around 400,000 of the 11.5 million children in England are in need or in care at one time – but intensive and highly specialist help is needed if these children are to have the opportunities that others take for granted.

4. Whether it is by finding a new 'forever family' for a child waiting for adoption, helping a child in care to understand their early experiences and settle in their foster home, supporting a disabled child to have the confidence to take part in the activities their peers enjoy, or working with struggling and distressed parents to understand where things are going wrong and what their children need to thrive – children's social care is vital and transformative.

5. And those working in social care do not, of course, do this work alone. Strong partnerships with schools, with the NHS and with the police are often vital to identifying issues and putting in place the right solutions for children.

"When I was growing up I had the same social worker for seven years. I felt like I could trust that social worker 100%. Our relationship wasn't easy, but she stuck by me through thick and thin. I always looked forward to seeing her – she was my special person. She worked with my family at the same time to protect me from my mum, who wasn't easy to work with, and she was always available to me. I didn't even realise there were other children on her caseload – it didn't even occur to me that I wasn't the only one because she was that good.

The first person I met that I really wanted to be like was my last social worker. She was so cool. She's still in my life now I'm part of her family. She was actually only 5 years older than me, I was 16 then. Sandra was so cool, she taught me a lot in life.
I was in care as a child, and so were both my parents. Two generations. My daughter didn't go into care - we're not repeating that pattern. My children's upbringing and success is a credit to my social workers; they were the ones who gave me the ability to break out of that cycle. Parents usually take the credit don't they? Well my parents lost that right, with my social workers gaining it. Social workers don't always see the impact, but boy can they make a difference. I have got to where I am today because of social workers."

Jenny Molloy, now a writer
'Hackney Child', Simon & Schuster, (2011)

The case for change

6. The best children's social care services in England deliver excellent help and support to children and families. But whilst there is much impressive social work in the system, evidence from frontline delivery organisations, multiple Serious Case Reviews and from Ofsted inspections points to continued inconsistency in the quality of work with children and families. Ofsted's recent Annual Report on children's social care states that, of those local authorities inspected under the current framework, a quarter have been found to be inadequate. In addition, almost half require improvement to be good. The majority of local authorities still struggle to provide consistently effective core social work practice. Similarly, fewer than half of

Local Safeguarding Children Boards, which coordinate and challenge multi-agency working locally, do so in a way which is 'good'.

7. Reviews by Professor Eileen Munro, Sir Martin Narey and David Croisdale-Appleby, amongst others, have given us a deep understanding of the challenges faced by children's social care. They have described a system:

- in which initial social worker training is not consistently preparing students for the challenges of the job, and those already doing it too often lack the time, specialist skill and supervision needed to achieve real change for children and families
- that focuses too much on management and is governed by prescribed approaches rather than excellent practice
- where services have not always been designed around vulnerable children, and innovation hasn't been given enough space to thrive

8. We do not underestimate the challenges that social care faces: increased pressures on budgets; higher demand for services; and new threats to our children and young people as they become targets for radicalisation, child sexual exploitation or gang culture. But we know that these challenges are far from insurmountable. The pattern of inspection outcomes is not about how deprived an area is, or local geography, or even the amount of money being spent on children's social care. Some of the local authorities judged 'inadequate' by Ofsted this year were amongst the highest spending, whilst higher performers were found to spend their money more effectively, investing in the best services and bringing costs down. Ofsted's inspections this year show that, regardless of local context, providing outstanding services is possible, and 'good' is a standard that any local authority can achieve and maintain.[1] It is our moral obligation to refuse to rest until every local authority does. We owe it to Daniel Pelka and Ellie Butler, killed by their parents, and to the more than 1,200 children in Rotherham who faced the most heinous child sexual

[1] Social care: the report of Her Majesty's Chief Inspector of Education, Children's Services and Skills (2016)

exploitation in the line of sight of people who should have intervened. We owe it to every child who has suffered without the help and protection they needed.

Progress so far

9. Over the last six years, we have begun to lay solid foundations for the improvements required. We have made significant progress towards reforming the child protection system, stripping back bureaucracy. We have secured crucial additional support for children in care and those leaving care. We have reformed the adoption system, to give more children a permanent family, more swiftly. We have helped 35 local authorities move out of failure, and established the first two children's social care Trusts. We have appointed a Chief Social Worker and introduced the first definitive statements of the knowledge and skills needed by child and family social workers. We have begun the transformation of the Special Educational Needs and Disability system, to join up social care, education and health, and put the child at the heart of the system. We have invested in Frontline and Step Up to bring more high calibre recruits into social work. We have introduced the Pupil Premium Plus, giving extra money to help schools to support children in care. We have invested £100 million in testing out radical new approaches to children's social care through our Innovation Programme.

10. This is all starting to have an impact: we have seen the first 'outstanding' Ofsted judgements under the current framework; we are recruiting a new generation of talented social workers into the children's social care workforce to complement some of the outstanding social workers who enter the profession from the traditional university route; and examples of exceptional leadership are being celebrated by Ofsted and others. Importantly, we are starting to see the emergence of a culture which strives for excellent practice and has the confidence to believe that it can be achieved.

Our reform programme

11. Building on that work, we have a real opportunity over the next five years to transform the quality of children's social care services in England. In January 2016, we set out our vision and our reform programme, under three fundamental pillars of reform:

12. This paper outlines in detail how we will deliver fundamental reform across each of these three pillars. It builds on the paper 'Adoption: a vision for change' which set out the government's vision for a reformed adoption system by 2020, and also responds to the important recent reviews by Sir Martin Narey and Alan Wood CBE, on residential care and multi-agency arrangements for safeguarding children respectively.

13. The government has a responsibility to support change and intervene where children's wellbeing is at risk. However it is important that local areas have the freedom and flexibility to find what works for the children in their care. We need reform to be locally driven, by leaders who know what works to help children, and by strong local partnerships. Help needs to be delivered in ways which fit the local context and the varying and complex needs of individual children and families, but to the same consistently high standards. The diverse examples of success that we are seeing are often the result of highly innovative structures, systems and practices. Their common ground is the relentless pursuit of excellent practice, irrespective of the challenge or environment.

14. By 2020 our ambition is that all vulnerable children, no matter where they live, receive the same high quality of care and support, and the best outcome for every child is at the heart of every decision made. Getting this right isn't just about changing lives, it's about transforming them. The reforms outlined in this paper will

give the entire children’s social care system the opportunity to do that. They will ensure that the whole system puts children first.

Chapter 2: People and leadership

In 'Children's social care reform: a vision for change' we set out our ambition to bring the best people into the profession; give them the right knowledge and skills for the vital work they do; and develop leaders equipped to nurture practice excellence.

To achieve this, we will:

- have an accredited practice leader in place in every local authority by 2020
- establish a new programme to develop our most talented social workers into the practice leaders of the future
- launch a programme for the development of new practice supervisors
- continue to invest in existing teaching partnerships and support new ones, to raise standards of entry into social work
- roll out a new system of assessment and accreditation for all child and family social workers, practice supervisors and practice leaders by 2020
- establish a new specialist regulator for social workers in England
- led by the new regulator, set new professional standards for social workers; new standards for qualifying education and training; and new specific standards for the continuous professional development of social workers

15. The individuals who make up the children's social care workforce have the opportunity to have a genuinely life-changing impact on our most vulnerable children. They will often find themselves to be the one person in a child's life who is both trusted enough to understand the problems the child faces and also skilled and confident enough to bring about the change that is needed to address them.

16. Our most vulnerable children are helped and supported by thousands of deeply committed child and family social workers, foster carers, residential care home workers, and a wider workforce made up of personal advisers, therapists, counsellors, social work assistants, family support workers and others. It is only through their skill, expertise and capacity to care that we can truly achieve the change we need for children.

Case study

Emily graduated from University having studied English Literature, followed by a Masters in International Development. Before joining the first Frontline cohort in 2014, she worked for a national children's charity. Now in the second year of the programme, Emily is working as a newly qualified social worker in a London Council.

Emily is extremely proud to have recently qualified and enjoys the variety of the work she does in child protection: "No day is the same in social work. I have had the privilege of working with families and children who are defying the odds to work through difficult situations. I have particularly enjoyed building relationships with clients to encourage collaboration and positive change. One of the best parts of this job is the people we work with, and although there are difficulties and challenges, there are often also success stories for families involved in social services."

17. This chapter focuses on our reforms to raise the skills and confidence of the social work profession. But foster carers, residential care workers and others also have a vital role to play. These people often provide the central relationship in a child's life, the foundation on which their stability, security and self-worth are built. They have to be able to love and nurture children who can often be resistant to it. They have to be hopeful and aspirational for children who feel others have given up on them, and who have sometimes given up on themselves. This work is not easy. Not everyone can do it and no-one can do it alone. Those who do, provide a priceless service to our most vulnerable children and to society as a whole. Chapter 5 sets out our emerging plans for supporting this wider social care workforce to do their vital work.

Developing the social work profession – achieving confidence in practice

18. Our vision is for a social work profession that has fully confident and highly capable social workers, who have been properly trained in the right way with the right knowledge and skills. They must have the opportunity to work in supportive environments, that facilitate critical thinking and enable them to make the best decisions for children and families.

19. Child and family social workers hold the statutory responsibility for keeping children safe and making the right decisions about their futures. Social workers know how to effect change within families, but also know when success cannot be achieved and they must pursue a stable and secure alternative family future for them. They have to be able to simultaneously build a strong, supportive relationship with a family whilst remaining open minded and forensically inquisitive about the risks a child could be facing. They know how to help young people build their social world and leave the care system brave, hopeful and equipped for the adult world.

20. There are great social workers and leaders in the system, and great local authorities that are excelling in the delivery of services to vulnerable children and families. But – across local areas and within local areas – the quality can be variable, with some social workers lacking the right knowledge and skills to do their job effectively, working under poor leadership and supervision, in systems that do not focus on what matters most: keeping children safe and supporting them to reach their full potential.

21. The knowledge and skills statements published by the Chief Social Worker for Children and Families for child and family practitioners, practice supervisors and practice leaders set out for the first time what social workers, at all levels of seniority, should know and be able to do, establishing the foundations for a clear career path for the profession. Ensuring that all social workers working with the most vulnerable children and families have the right level of knowledge and skills is a key priority.

Case study

Anna Banbury has worked at the NSPCC since 2013, where she is Development and Impact Manager for Child Sexual Exploitation (CSE) policy, practice and research. She trained and qualified as a social worker from the University of Oxford in 2003 and began her career as a social worker in the Royal Borough of Kensington and Chelsea.

Anna is motivated by the unfairness that for some families, things are harder: “Change takes a very long time: it is hard and frightening and needs someone to stand alongside you to reassure and support. That’s the job of a social worker. We all know that there is never enough time to spend with our clients, but I have come to value research and reflection as much. So much depends on the quality of our decisions and our records. It can be hard to remember that what feels like cumbersome paperwork at the end of a long day is a person’s life story. One day they will need those records to make sense of what has happened. The hardest part about being a social worker is knowing that, for some people, our support comes too late. The hurt and harm that could have been prevented are now too deeply embedded. And we must be able to explain and evidence that. But my passion for the work comes knowing that I am helping to draw a line in the sand: for this child or this family, the cycle can be broken and there is hope for the future. Change is possible. And we can evidence that too.”

Developing leadership to transform children services

Definition of practice leader – knowledge and skills statement

Practice leaders are qualified social workers with the day-to-day operational responsibility across the whole local system for child and family social work practice, for child and family practitioners and practice supervisors. They are typically referred to as the Assistant Director of Children’s Social Care or Director of Family Services.

22. As the most senior qualified and experienced social workers in an organisation, practice leaders are in a unique position to lead and to improve practice. Practice leaders provide clarity of organisational purpose, create the context for excellent practice, are able to design systems to support effective practice, develop excellent practitioners, support effective decision making and set and uphold high quality

practice standards. They instil a strong sense of accountability in staff for the impact of their work on the lives of children and families, being committed to continually improve the services provided. The importance of this role has recently been recognised in the Ofsted note on practice leadership[2]:

"The qualities that make a successful children's services leader aren't straightforward to define – but inspections show that they're very obvious when present – and strikingly so when they aren't.

"It isn't just a question of good leadership and management skills, although these must be present in abundance. Like all good leaders, social work practice leaders are inspirational and influential. They are energetic, visible, and ensure that they are surrounded by a strong team at every level."

23. Our ambition is that all local authorities will have an accredited practice leader in post by 2020. Some local authorities may choose to have more than one practice leader in place, but it is essential that in appointing more than one practice leader the essence of the role is not diluted, losing the clear line of leadership, accountability and ownership over the quality of practice. As with the wider social work profession, it is important that practice leaders are centrally accredited to build professional and public confidence around them. The first group of practice leaders will be accredited in 2017.

24. As announced by the Secretary of State in January 2016, it is important that we start investing now in those talented social workers who will be the practice leaders of the future. As part of their work as a Partner in Practice, Tri-borough (Westminster City Council, London Borough of Hammersmith and Fulham, and the Royal Borough of Kensington and Chelsea) will lead work to develop and deliver this programme, with the support of other Partners in Practice and high performing local authorities. The programme will have input from the best existing practice leaders and will have a particular focus on developing the pipeline of future leaders to work in challenging areas and newly-created Trusts.

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[2] Schooling E, 'Practice leadership', Ofsted, Commentary on social care: June 2016

Bringing the very best into the profession and improving the quality of education

25. The main route for people to enter child and family social work is through a generic three-year social work degree or a two-year Masters. As the Narey Review (2014)[3] showed, the quality of these courses is hugely variable. While some courses are very strong, some accept poor calibre individuals, have too limited a focus on the skills and knowledge needed to be a social worker, and lack high quality practice placements. Universities are too often insufficiently responsive to the voice of the employer. And only a proportion of those being trained ultimately end up working as social workers. Latest figures show that only 3,000 of the 4,700 qualifying from social work programmes (65%) have entered the profession six months after the end of their course.[4]

26. We need more high calibre recruits to enter social work, taught through a curriculum based on the knowledge and skills they need to work with the most vulnerable children and families and assessed against the knowledge and skills statements. Supportive, high quality statutory placements are also fundamental for their effective future practice.

27. During the last Parliament we invested in establishing and developing two successful new entry routes – Frontline and Step Up. Both programmes build on the generic foundations of social work with a specific focus on the knowledge and skills required to operate effectively in a child and family statutory setting. Both programmes have been very popular with both high calibre students and employers.

28. Our ambitions for these fast-track routes are therefore high. By 2018 we anticipate around 30% of new child and family social workers will come from fast-track routes, and up to 40% by 2020.

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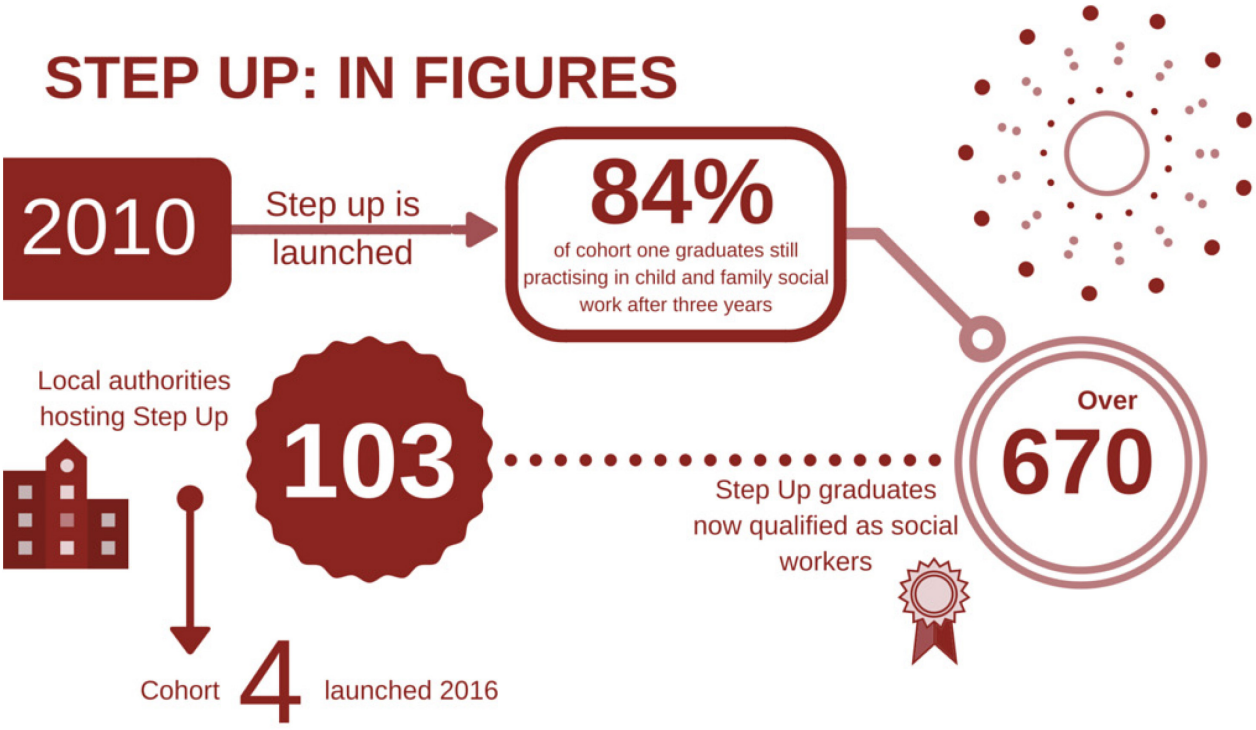
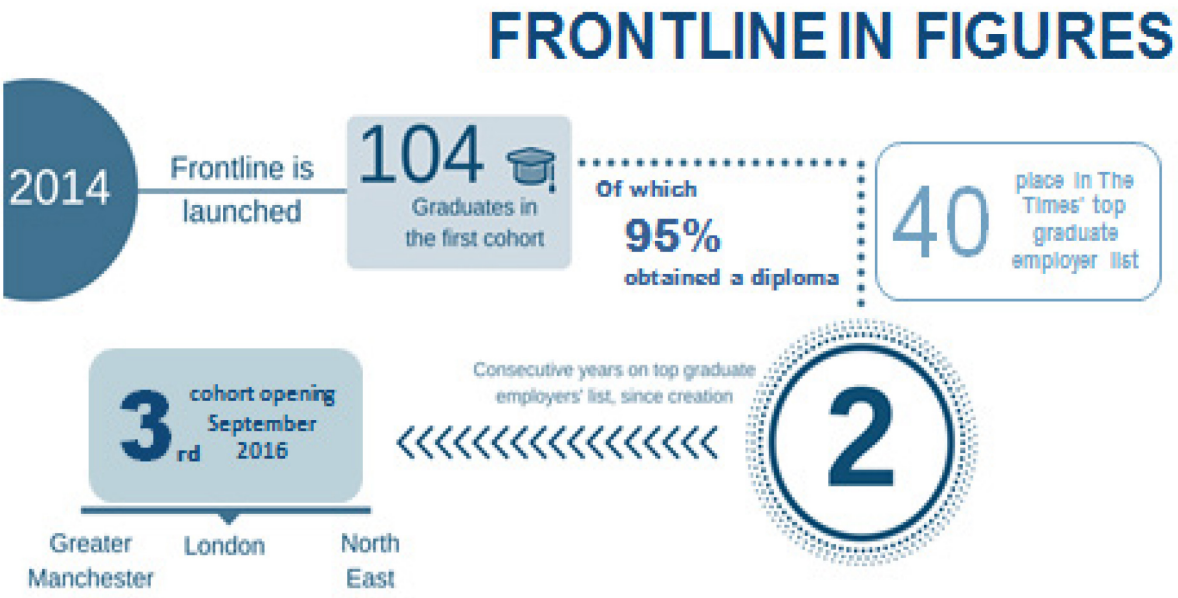
[3] Making the education of social workers consistently effective: Report of Sir Martin Narey's independent review of the education of children's social workers (2014)
[4] Social Work, Skills for Care, March 2016, page 12. https://www.nmds-sc-online.org.uk/Get.aspx?id=957463





29. In 2010 Step Up operated in just 42 local authorities; now 103 local authorities are hosting the programme. Frontline will expand from the London and Manchester areas into the North East from September 2016 and the West Midlands from September 2017. **We want every local authority to have the opportunity to benefit from at least one of these programmes by 2020 and will work with local authority senior managers to ensure full national coverage.**

30. But standards of education must rise across the board, with no tolerance for courses that fail to prepare students for the realities of statutory work. In 2015 the Department for Education, together with the Department of Health, launched four teaching partnerships, bringing together a range of local authorities, other social care and health organisations and universities. These partnerships are raising standards of entry into conventional social work programmes, are incorporating the Chief Social Workers' Knowledge and Skills into teaching and practice curricula and have a strong focus on statutory placements.

> "Teaching partnerships play a key role in transforming social work practice. The teaching partnership has re-energised and re-focused our commitment to and passion for social work as a true vocation. Feedback we have received reaffirms the value of teaching partnerships being employer-led and responsive to the needs of the statutory sector in a way that has never been seen before."
>
> **Christine Bennett**
> Assistant Director (Children Fieldwork Services), Sheffield City Council
> and Chair of the South Yorkshire Teaching Partnership

31. We continue to invest in existing teaching partnerships and will support new ones to build on the positive impact already achieved. The interest in the teaching partnership programme continues to grow with 23 new applications received for phase two of the programme from a total of 98 different local authorities, 43 universities and a range of other public sector, private, voluntary and independent organisations. A panel led by the Chief Social Workers for Adults and for Children and Families is reviewing these proposals and making recommendations to ministers for expansion.

32. The teaching partnerships programme paves the way for the standards that the new social work regulator will set across the board. Although the exact details of these standards will be for the new regulator to decide, it is expected that they will build on the requirements for teaching partnerships including promoting high entry requirements, focus on the Chief Social Worker's knowledge and skills statements, a strong emphasis on statutory placements and continuous professional development (CPD) that supports the new career framework. The expansion of the teaching partnership programme enables institutions to work towards those standards.

Developing confidence in the social work profession – assessment and accreditation

33. Social work can be a lonely job and proper supervision and support is vital to doing it well. Quality of individual practice is variable, with different standards and expectations being applied by different employers. Although the knowledge and skills statements set out in clear terms what child and family social workers are expected to know and be able to do, there is no nationally consistent mechanism to demonstrate whether individual social workers are able to meet these standards.

34. The assessment and accreditation system will provide that mechanism, so that employers and the public can therefore be assured that social workers meet these expectations. It will offer an opportunity for social workers to demonstrate the quality of their practice through a test of their knowledge and through observations of simulated practice in a number of role play scenarios with actors. It offers both the opportunity to develop the confidence of the public in the profession, and for the profession to develop confidence in the quality of its own practice against clear standards.

35. During the proof of concept phase, which ran from April 2015 to March 2016, almost 1,000 social workers took part and helped the department shape the future of the system. We plan to publish our conclusions about the proof of concept phase and what it means for the future of the assessment later this year.

36. This will be published alongside a consultation document on the future of the assessment and accreditation system, covering the key questions about the future implementation of the system. This will include whether accreditation should be made compulsory and, if so, for what roles or functions, and the consequences of failing to achieve accreditation. If accreditation were to be made compulsory, this would not be until after 2020, when we expect all child and family social workers to have had the opportunity to be accredited.

37. From 2017 to September 2018 (phase 1 of the rollout), our Partners in Practice and a group of volunteer local authorities will help the department shape delivery, and pioneer the assessment with their workforces. Social workers who have recently

completed their Assessed and Supported Year in Employment are also expected to be part of this phase.

38. Phase 1 of the rollout will give us the opportunity to gain a better understanding of the impact that assessment and accreditation has on the workforce and the ability of employers to manage the implications for their staff. It will also enable us to develop a robust infrastructure to support further rollout and pass responsibility to the new social work regulator at that time.

39. **We intend to publish guidance later this year to support employers and social workers to embed the knowledge and skills into their practice.**

40. **We will launch a tender for the selection of a delivery partner to support phase 1 of the rollout alongside the publication of the consultation and the results of the proof of concept phase.**

Investing in continuous professional development

41. Learning does not stop at qualification and we know social workers are eager to continue to develop their own practice, with many employers providing a programme of post qualification training and development.

42. The transition from initial qualification into the realities of practice is a crucial time in the development of a strong social work professional. Previous work experience, quality of classroom and practice teaching, type of student placement, curriculum content and the quality of support provided by the employer all have an impact. The Assessed and Supported Year in Employment (ASYE) helps bridge this transition, ensuring newly qualified social workers are supported to become confident in practice and evidencing that they can apply their social work knowledge and skill to particular work contexts.

43. Nearly 10,000 child and family social workers have been supported through ASYE, with over £18 million invested over the past five years. We know that this programme is highly valued but we also know that the level of support participants receive is variable and standards fluctuate across local authorities. The introduction of the knowledge and skills statements and assessment and accreditation provides an

opportunity to strengthen this programme, with ASYE participants expected to gain accreditation following completion of their ASYE. **We will continue to invest in ASYE, with the launch of cohort 5.**

44. Moving from initial qualification into work is not the only transition that social workers will face. Moving into supervisory roles is equally important and it is essential that social workers are supported in this transition to ensure they are properly able to supervise and support others under their responsibility**. That is why we will establish a new programme for the development of those making the transition from frontline practice into practice supervision, akin to the ASYE for frontline practitioners. The programme will launch its first cohort in 2017.**

45. Alongside the core social work reform programme, we are keen to provide social workers with opportunities for rigorous continuing professional development which promote depth of practice in key areas of child and family social work. As announced in 'Adoption, a vision for change' the first area of practice we want to focus on is the knowledge and skills required to achieve permanence for children within and outside the social care system. **We are creating a new optional training programme to support social workers to develop or sharpen skills they need in order to make and support robust permanence decisions**. The content of the training will be based on a specialist statement of knowledge and skills. This statement will set out what a child and family social worker needs to know and be able to do in order to successfully undertake the complex assessment, analysis and permanence decision-making we require of them, and progress permanence plans with urgency and skill. A formal consultation on the proposed knowledge and skills statement will be published shortly on the gov.uk website. We will use this area to trial this approach to developing depth of practice and then consider whether additional areas of child and family social work would benefit from a similar approach.

A new regulatory body for social work

46. Social work is a complex and challenging profession that has the power to transform lives. Key to this is a highly skilled and expert workforce. However, we know that excellent practice is not found consistently across the country. As set out above, the government has developed a significant reform programme to improve social work quality and the quality of the systems which support social workers. To embed these

reforms, we need a regulatory system that focuses on practice excellence and raising standards from initial education through to post qualification specialism.

47. Subject to the passage of the Children and Social Work Bill a new specialist regulator for social workers in England will be set up. The new regulator will cover both child and family social work and adult social work and will have an absolute focus on raising the quality of social work education, training and practice with children young people, families and adults. This will help improve public safety and promote the status and standing of social work. To achieve this the new regulator will:

- publish new professional standards, aligning with the Chief Social Workers' knowledge and skills statements
- set new standards for qualifying education and training, and reaccredit providers against these standards by 2020
- maintain a single register of social workers, annotating it to denote specialist accreditations
- set new, social work specific, standards for continuous professional development
- oversee a robust and transparent fitness to practise system
- approve post qualifying courses and training in specialisms such as Approved Mental Health Professionals and Best Interest Assessors
- oversee the proposed new assessment and accreditation system for child and family social workers
- oversee the required arrangements for successfully completing the ASYE
- make effective use of workforce-related data available to it to offer insight and advice which informs and supports workforce planning by both local and central government

48. On 28 June, the government published a policy statement that set out the vision for this vital area of reform.[5] To achieve these ambitions collaboration, consultation and engagement with the social work sector will be vital and that will be a key feature of the development and running of the new regulatory framework.

[5] 'Regulating Social Workers: Policy Statement' (June 2016)

Extract from 'My Heroes… My Happiness…'
By Steven, Year 8, Luton. Winner of Coram VOiCES writing competition 2016

"I lay there like death lies over the graves of the living. Jumping into the darkness of the night like light jumps into the darkness of the abyss. My life being shadowed like the British clouds shadow the light and all that is good for this world. Being drowned into the depths of the ocean like a fish gets drowned in the depths of the air. My soul being burnt like the rain burns the fire to the deepest pits of hell. But still I am happy, and the two people who make this possible...

My heroes… Clint and Estelle… I had felt a new emotion that I had never felt before. I was greeted by happiness. I was greeted by another feeling that I had never felt before when I met them… love. My eyes filled with tears of joy as I struggled to keep in the happiness. Warmness flooding through my veins. A sigh of relief as I felt as though I had found my safe haven…

Struggling to control my emotions as strangers became my friends and friends became my family. Could I have been there? Was I in heaven? Every day I asked myself these exact same questions. But then I have to come back into reality and realise that I was still in this same world of war and torment. But with these people helping me through my poisonous life I can do it and I will eventually become stronger and no longer crying my way to sleep every night…

The past ten years of my life have been the best I have ever experienced. Our family is like the story of Romeo and Juliet except in our family the love is returned because there is always love and sometimes it is consistent and that is why I love my family and they love me in my family. They are my heroes. They are my happiness. I love them loads…"

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Chapter 3: Practice and systems

In 'Children's social care reform: a vision for change' we set out our ambition to create a system that provides the right environment for excellent social care practice and innovation to flourish; learns from the best, and learns when things go wrong; and frees up social workers to use their skills and talents to the full.

To achieve this, we will:

- expand the Innovation Programme through the £200 million additional investment announced in April, launching a new bidding round in September 2016
- work with our eight leading local authorities as Partners in Practice to: understand how authorities get to good and what it takes to move from good to excellent; interrogate the most important practice questions facing children's social care; and develop additional sector-led, peer to peer improvement
- seek to use a new Power to Innovate to test where legislation, regulations and guidance might be getting in the way of excellent practice
- launch a new What Works Centre for children's social care
- establish a new national framework for inquiries into cases of serious harm to children
- develop effective responses to new and emerging threats
- move from a system of data collection to data-driven practice, and improve the quality and collection of data

49. This chapter is about what the children's social care workforce does when working with children and families – making sure that they are intervening in a way that will make a genuine, long lasting difference to children and families.

50. We mostly know who the children in need of support, care and protection are, and we know a lot about their family life, their experiences and the challenges they are facing. But what we don't yet understand deeply enough is whether what we are doing to support them is actually helping. In order to put children first, we need to foster a resilient and dynamic practice system, underpinned by a robust and continuously evolving evidence base. We need a national learning infrastructure that brings

together everything we know about the best ways of helping our most vulnerable children, and makes this available and easily accessible to the whole system. The future we want to see is one in which excellent professionals do not shape their practice to comply with diktat from Whitehall, or even the Ofsted framework – but rather they form a confident profession, constantly pushing the boundaries and redefining what works through rigorous and evidence-based practice.

51. Actions taken in the last Parliament have already started to develop our understanding of how excellent practice can be unleashed. Our £100 million investment in innovation has energised the sector, and built consensus around the need to push boundaries and rigorously test and verify new approaches. Emerging messages from the first round of our Innovation Programme, and from the Ofsted annual report and commentaries, suggests that the following are key features of successful children's social care systems:

- leaders know what excellent social work looks like and fearlessly put children's needs first, and resources, or corporate pressure, second
- leadership and governance brings teams and organisations together around a 'golden thread' of a clearly thought-out, coherent vision for improving the lives of children – creating shared values and purpose that is championed by leaders but owned by everyone
- social work methods and practice focus on strong relationships – strengthening the relationships at the heart of children's lives to increase stability, create real change for birth families, and better support children and young people
- the workforce culture creates an enabling environment and common practice between professionals – a single theory of practice across the whole workforce so professionals are speaking the same language and working in a consistent way with children and families; with manageable caseloads; high quality reflective supervision and clinical support for staff; time to do direct work with families; and integrated, inter-disciplinary and cross-agency teams
- system conditions enable new approaches to take off – which can be created by new delivery models focused exclusively on children's social care, and/or by new approaches to commissioning and funding which put children's needs front and centre

- staff are challenged and supported to take appropriate managed risks – leaders and managers who take responsibility and don't seek to apportion blame

52. Our ambition for developing the practice system now is to:

- deepen our understanding of the system conditions needed for excellent practice, and properly understand how these can be fostered across children's social care organisations
- investigate and build our evidence base on the biggest and most important practice questions and challenges facing children's social care
- work out what it takes to move organisations from good to excellent
- extract, properly understand and disseminate lessons from analysis of the most serious incidents of abuse and neglect
- boost sector-led improvement and development, where the best authorities support those who are struggling, and authorities work together in a concerted way to tackle cross-system and cross-boundary challenges
- establish a national repository of knowledge and insight, bringing together everything we know about what works for our most vulnerable children and families, and identifying priorities for further investigation

53. To achieve this, we will expand the Innovation Programme, establish a new Partners in Practice programme to work with our leading local authorities, make better use of data to improve practice, and take a new approach to learning from serious incidents. We will also create a new What Works Centre for children's social care, giving professionals the authoritative and trusted voice on 'what works' in social care practice and systems that they both need and deserve. Collectively these actions will add up to a new national learning infrastructure, the role of which will be to create a deeper understanding of practice excellence, and spread that across the country.

Supporting greater innovation

54. The Children's Social Care Innovation Programme is the vehicle by which we will test new approaches to tackling the most important and difficult practice questions facing the children's social care system. The programme is already supporting local authorities and other organisations to develop new approaches to children's social

care with an investment of over £100 million in 53 projects, and in April this year we announced a further £200 million investment to extend the programme.

Case study

Pause's 'Preventing Repeat Removals' project received £4.3m of funding for their work to break the cycle of children being removed into care, often related to complex trans-generational patterns of neglect or abuse. Pause's aim is to break these cycles by intervening at a point when women have no children in their care, working intensely with them through a systemic, integrated model. Pause is currently delivering across seven areas in England, working intensively with up to 20 women at each area.

Evidence has so far demonstrated a number of positive outcomes as a result of the intense therapeutic, practical and behavioural support, provided through a one-to-one Practitioner relationship. As well as a reduction in pregnancies and removals, many women are now in safe accommodation, receiving help and support from domestic violence or mental health services, and engaged in training and education, as well as volunteering and employment. Some women have reengaged in positive and consistent contact with their children, with feedback beginning to demonstrate a positive impact on children.

55. So far the Innovation Programme has focused on three areas:

- rethinking children's social work – these projects have started to show evidence that giving social workers and other frontline workers freedom and support to design services that they know children and families need can have a dramatic impact, and includes projects that have redesigned the organisational systems and practice frameworks
- rethinking support for adolescents in or on the edge of care – including projects providing integrated models of support to young people on the edge of care, and new models for specialist foster care and foster care working in partnership with residential care to create greater stability for young people
- other innovative ideas outside these two priority areas – giving the opportunity for the sector to drive reform where it is most needed, such as the work that the Council for Disabled Children have been doing with five local authorities to explore

challenges and potential solutions in relation to the assessment of disabled children, young people and their families

56. These priorities continue to be central to the programme. Indeed, we are continuing to support projects with positive results and where there is good potential for replication. We are also enabling projects to extend their evaluations.

57. The next phase of the Innovation Programme is a real and enduring opportunity to strengthen and spread the best ideas so far and to drive more innovation in new areas up to 2020.

Case study

Tri-borough (Hammersmith and Fulham, Kensington and Chelsea and Westminster local authorities) have implemented their ambitious new model called Focus on Practice, a project designed to bring greater coherence and confidence to social work practice, embed a new culture based on systems thinking and reduce the number of re-referrals of family cases and the number of children in care. The main idea is that social work should be encouraging families to seek solutions for themselves, with the support of practitioners. Focus on Practice involves employing clinicians (family therapists and clinical psychologists), which is proven to be making a difference to social work practice. Clinicians are seen as authentic experts, an extra resource to help resolve 'stuck' cases. They are embedded in teams and provide social workers with systemic ways of tackling problems. The first two 'outstanding' Ofsted judgments under the new framework were recently awarded to two of the authorities in this project, and the programme was cited as contributing to their success.

58. We need to use the next phase of the Innovation Programme to make progress on two fronts:

- deepen our understanding of the system conditions needed for excellent practice, building on the messages emerging from phase one of the programme, and supporting more local authorities to rethink their whole practice system around these conditions

- investigate and build our evidence base on the biggest and most important practice questions facing children's social care, including building on phase one by continuing to develop our understanding of how we can best support young people making the transition to adulthood

59. In response to Sir Martin Narey's report on residential care, and building on the adolescents strand of phase one of the Innovation Programme, local areas will be invited to test innovative new ways in which residential care could be used in a more dynamic and creative way to support children and to link seamlessly with other care placements and with other services. In response to Sir Martin Narey's specific recommendation, we are committed to introducing Staying Close for young people leaving residential care. Staying Close – similar to the Staying Put arrangements which exist for children in foster care – will enable young people to live independently, in a location close to their children's home with ongoing support from that home. As Sir Martin recommends we are going to pilot variations of the scheme, in order to understand the costings, practicalities and impact first. We will also make Innovation Programme funding available for local authorities to come together in larger scale commissioning arrangements for residential care placements to test Sir Martin Narey's view that this could lead to significant savings, wider placement choice and better outcomes for children.

60. We also want to use social investment to improve the way that care leavers are supported as they make the transition to independent living, and particularly to support their sustained participation in employment and training. Where providers succeed in doing so, they will be paid for their 'social impact'. We will make funding available from the Innovation Programme to support the development and commissioning of care leaver Social Impact Bonds over the rest of this Parliament to test new approaches.

61. We are also keen that the next phase of the Innovation Programme has a focus on testing out alternative delivery models for children's social care (see chapter 4). Whilst structural change is not an end in itself, there is emerging evidence that, in the right circumstances, it may be the key to unlocking improvement and innovation. We want to use the Innovation Programme to build our evidence base in this area.

62. **The Innovation Programme will open for its next round of applications in September 2016.**

Understanding and spreading excellence through our Partners in Practice

63. Our Innovation Programme has started to develop our understanding of the conditions needed to create excellent practice in children's social care. What is clear is that some local authorities – all of whom are already engaged in the Innovation Programme – are achieving this already. These are the authorities we want to make our 'Partners in Practice'. We want to work with the Partners in Practice local authorities, as the leaders in their field, to achieve the following:

- interrogate how these authorities got to good, and further develop our emerging understanding of the conditions needed for excellent practice to flourish
- work out how authorities can go from good to excellent – by providing freedoms, flexibilities and other forms of support, we want to see just what these authorities can achieve when barriers are removed, creating a model of excellence that the whole system can learn from
- boost sector led improvement, by backing the Partners in Practice to drive improvement in authorities still working to get to good
- use these leading authorities to contribute to our effort to investigate the most important and difficult practice questions facing the children's social care system

64. This is an approach that puts genuine partnership between local and national government at the heart of work to improve services, with our very best practitioners and leaders in the driving seat of reform for children and young people.

65. We want the Partners in Practice to help us fundamentally rethink the framework in which social workers operate and social care leaders design, manage and quality assure their services. In particular, they will provide evidence about new structural models and innovations; trial the new social work workforce reforms; explore greater freedoms in how they design and deliver their services; and support work looking at how best to measure performance and outcomes. They will also tackle some of the hardest practice questions facing the system, adding to our understanding of what actually works to make change happen for the most vulnerable families.

66. We will undertake rigorous evaluation of how the Partners in Practice authorities work to provide the sector with insight on what works to improve outcomes for children and also how local authorities could move from ‘good’ to ‘outstanding’. As this work and our other reforms take effect, we will take on more Partners in Practice.

Case study

Lincolnshire County Council: Partners in Practice

Our ambition is to use the power to innovate to redesign how social work is delivered. We will reduce unnecessary bureaucracy and enable social workers on the front line to spend more time working with families and less time sitting in front of their computers and filling in forms. It will allow social workers to make real, lasting, effective change for the better in the lives of families, doing the job they expected to do when they trained for it.

We will use the most recent research on the education of children in care and develop a programme that aims to ensure that their progress educationally is better than what is expected. This will be done by creating a new approach based on a "Caring Schools and Learning Placements" methodology.

The way in which we currently make plans for our children in care is too bureaucratic, adult focused and time consuming. We will redesign care planning by putting children in charge of the decisions about their lives in a way that engages them to respond.

We will explore an alternative delivery model of Children's Services and explore opportunities for more collaborative working. Lincolnshire County Council has a track record of introducing effective new models through commissioning and has stated its aspirations to be a commissioning council. We believe that an alternative delivery model will open up opportunities for greater collaboration to drive efficiencies and improvement.

Removing barriers to effective practice

67. One important ambition for our Partners in Practice programme is that we use this programme to work out what children's social care organisations should *stop* doing in order to be great, as well as what they need to do. Putting children first means freeing up social workers to deliver genuinely high quality practice and drive better outcomes for our children, and we recognise that achieving this means stripping back some of the process and bureaucracy that gets in the way. While it is crucial that the children's social care system is effectively regulated, with appropriate safeguards and standards, we must be careful not to step into over-prescription, which constrains innovative, locally developed practice.

68. We have already made progress. Following Professor Eileen Munro's 2011 review of child protection, we substantially reduced and streamlined our 'Working Together to Safeguard Children' statutory guidance in 2013, ensuring that it focuses clearly on the core legal requirements that all professionals should follow to keep children safe.

69. Within the revised guidance, we streamlined the assessment process, removing the distinction between initial and core assessments and creating a single, continuous assessment process better geared towards ensuring that children are given the right help at the right time. However, in 2013 we fell short of fully implementing another of Professor Munro's recommendations by retaining a 45 working day timescale for the completion of the single assessment. We have been trialling exemptions from this and other timescales in statutory guidance for a number of years and we will now explore whether the time is right to remove these more broadly.

70. We need to continue to ask rigorous questions about which elements of our work with children and families genuinely add value, and which do not. There is a consensus stemming from the Munro Review that over-regulation gets in the way of good social work practice and prevents social workers and other staff from putting children first. In recent years the government has been working to create the conditions for local authorities and others to test radical new approaches that improve outcomes and efficiencies in children's social care. The Innovation Programme has already generated an exciting suite of projects that test the limits of the current framework – but local authorities tell us they often want to go further for children and families than legislation allows.

71. Our Partners in Practice will help us to do this. Many areas still feel unable to take measured and managed risks in the interests of children for fear of falling foul of prescribed approaches. In many cases the work that the Partners in Practice want to do means taking a fresh look at established practice, legislation and regulation and thinking hard about how far it genuinely supports the sort of changes we want our social workers to be able to make in the lives of young people. We need them to show us what they are capable of achieving when they are given the freedom to design practice around an uncompromising focus on what children and families need.

72. In order to safely test and evaluate the removal of barriers that social work leaders tell us get in the way of good practice, **we are seeking a new 'Power to Innovate' through the Children and Social Work Bill, currently before Parliament.** This would create a controlled environment in which we could enable local authorities to test deregulatory approaches that are not currently possible, before taking a decision to make substantial changes to existing legislation that would apply across the board.

> "I welcome the introduction of the power to innovate set out in the Children and Social Work Bill. This is a critical part of the journey set out in my Independent Review of Child Protection towards a child welfare system that reflects the complexity and diversity of children's needs. Trusting professionals to use their judgement rather than be forced to follow unnecessary legal rules will help ensure children get the help they need, when they need it. Testing innovation in a controlled way to establish the consequences of the change, before any national roll out, is a sensible and proportionate way forward."
>
> **Professor Eileen Munro**

Effective responses to new and emerging threats

73. Familial abuse and neglect remain the biggest reasons for children to be in the child protection system. But our children now also face new threats: from online abuse, made easier via access to social media and the Internet; from sexual exploitation through gangs and from peers; and from extremist ideologies. As a result, local authorities and social care Trusts need to understand how the risks presented by non-familial abuse are being picked up by children's social care, and what interventions are needed in response.

74. In the aftermath of shocking child sexual abuse in Rotherham and elsewhere, the Department for Education and the Home Office have worked with local authorities to understand the nature of the threat and the appropriate social work response. The report of the joint targeted area inspections into child sexual exploitation have also helped significantly and **we have now let a contract with the National Working Group for a Child Sexual Exploitation Response Unit, to bring expertise and support to those local authorities who face new or particularly challenging child sexual exploitation issues**. Given this is a fast moving area of practice that has been subject to recent developments, we recognise the role for government in bringing together examples of effective approaches, **and intend to publish new practice guidance and a revised civil definition of child sexual exploitation later this year**. This will help further with spreading good practice about dealing with child sexual exploitation.

75. Similarly, we have just completed the first phase of research to understand what best practice is when tackling issues of radicalisation of children. Here too, we are committed to supporting local authorities to build capacity and capability in these emerging areas of practice.

Understanding why serious incidents occur

76. Learning from the most serious incidents of abuse and neglect has to be a core part of our new national learning infrastructure. The current Serious Case Review (SCR) system seldom gets to the heart of why things went wrong. Reviews take too long to carry out and, as the national panel of independent experts has stated, the quality of reports is 'disturbingly variable, with good reports being outnumbered by those still failing on key points'. We need a system in which families, practitioners and the public can have confidence. 'Children's Social Care Reform: a vision for change' announced a move to a more centralised system. This will create a more sophisticated understanding of the factors in serious case reviews, so that local agencies can improve the quality of the services that they provide to vulnerable children and families. This will bring greater consistency to public reviews of serious incidents involving children; improve the speed and quality of reviews at local and national levels; make sure that reviews which are commissioned are proportionate to the circumstances of the case they are investigating; and support the development of both national policy and local practice.

77. To support this, **we intend to establish, through the Children and Social Work Bill, a Child Safeguarding Practice Review Panel to oversee a national framework for inquiries into cases of serious harm to children.** The current system of SCRs and miscellaneous local reviews will be replaced with national and local child safeguarding practice reviews. National reviews will include reviews of the most serious and/or complex cases, and will be undertaken when the Panel believes that the cases involve issues of national significance. Commissioning of local reviews will remain with local areas. This picks up some key recommendations in the review of the role and functions of Local Safeguarding Children Boards undertaken by Alan Wood CBE earlier this year. We will make sure that the outcomes of these reviews are properly analysed and disseminated through the new What Works Centre.

Using good data to improve practice

78. The relentless pursuit of excellent practice across the system will depend on high quality data being shared and used. At a national level, data should inform policy and legislation about children's social care; help us target support and challenge to local areas; and facilitate local learning. At a local level, data can ensure that the need for help is identified early; resources are targeted appropriately; services are commissioned effectively and efficiently; risk is managed well; and the right support is put in place for children and their families.

79. We have sought ways to reduce the burden of data collection, and increase quality (such as improved workforce data on social workers). We have also developed new ways of sharing data, for example by adding a range of special educational needs and disability (SEND) data to the Local Government Association's LG Inform tool. This helps local authorities compare their SEND performance more effectively, and the Local Authority Interactive Tool enables authorities to compare their performance with peers, with both tools including financial benchmarking.

80. Strong local authorities are increasingly using data to inform commissioning and resourcing decisions, and to monitor the support provided to children, for example using their registers of disabled children to ensure that they provide the support services needed in the right places. Central government, local authorities, and other public sector organisations need to know their unit costs and how these costs compare, to make the best decisions about services and to manage successfully in

the current budgetary climate. We want to encourage local authorities to make the best use of financial planning and comparator tools, such as that being produced by Aldaba and the Dartington Social Research Unit, in their commissioning and planning decisions.

Case study

West Sussex County Council has teamed up with local charity Amaze, to manage Compass West Sussex, West Sussex County Council's disability register for 0-25s. Joining the register will entitle children and young people with special educational needs and disabilities access to the Compass Card West Sussex, a leisure discount card and the opportunities this offers. West Sussex has used this approach to support families to engage with their community and to encourage them to sign up. The register will provide a rich data set that they can use to inform better commissioning decisions and better engagement with those families.

81. Despite this progress, however, we still do not get full value out of the wealth of data we collect; the quality and timeliness of data varies; and at its extreme data collection can divert resource away from working with children and young people. Too often, data are used primarily to try to indicate good or bad performance at specific intervals, rather than to identify opportunities to improve outcomes for children on an ongoing basis. Leaders and practitioners report that the way we share data does not always meet their needs and that local authorities can lack the tools, and capacity to fully utilise data to improve practice and outcomes for children.

82. To help us move from a system of data collection to data-driven practice, we will:

- work with local areas and organisations including the Association of Directors of Children's Services (ADCS), the Local Government Association and the Adoption Leadership Board to explore better ways of sharing data and analysis, and to understand barriers within local areas to using data

- promote effective practice to support authorities to use data to improve practice, manage risk, improve commissioning, and scrutinise their costs. This will include working with the Behavioural Insights Team to ensure that lessons from the big data project are disseminated effectively to local authorities; and sharing tools

and findings from work by the government and Boston Consulting Group on costs of local authority services

- identify opportunities to use national data in a more innovative way, for example analysing data from across government to identify trends that could help us target resources more effectively

83. We will also improve the quality and collection of data by:

- ensuring that everything we collect is collected for a clear purpose, and based on what central and local government find most useful, including working with local government to look at improving the section 251 data collection

- working with Ofsted and government departments across Whitehall to ensure data requests are as aligned as possible and duplication minimised

- encouraging better benchmarking of value for money data and lessons from Innovation Programme projects, to help local areas to meet the challenges of the current fiscal climate

- exploring how we can make fuller use of technology to improve how we collect and share data, and to move towards more timely data

- developing a framework of what good local data looks like, led by Partners in Practice, based on early work which indicates that there is consistency in the type of data strong local authorities collect

84. Performance data are crucially important in managing the provision of effective services but, as Professor Munro identified in 2011, should not be treated as unambiguous indicators of performance, particularly in child protection where the majority of information available is more nuanced. At the moment, however, local areas report that meaningful performance indicators are, at best, buried within the surfeit of data they are required to collect.

85. Bearing Munro's findings in mind, we will explore whether there is an appetite for developing a streamlined set of measures across children's social care, or for specific groups of children. We are considering, for example, how to make better use of the rich data already collected on children in care and care leavers, including looking at

the development of an outcomes framework consisting of the most useful indicators of success, to enable better local authority decision-making.

Establishing a new What Works Centre

86. Our new What Works Centre (WWC) is our long term solution to bringing together in one place our national understanding of practice excellence. For some time now social workers and practitioners have been asking for a children's social care equivalent of NICE for the NHS or the Education Endowment Foundation for education. It is important they have an authoritative and trusted voice on 'what works' in social care practice and systems – testing the strength of the evaluated evidence and disseminating key messages. This is exactly why we are establishing a new What Works Centre for children's social care.

87. The WWC will have a sharp focus on improving outcomes for our most vulnerable children and their families. It will identify best practice in supporting children suffering from, or at risk of, abuse and/or neglect from targeted early support all of the way through to permanence. By looking at both effective interventions and practice systems we expect that the WWC will be able to build a truly comprehensive picture of what excellence looks like.

88. While building the evidence base in children's social care is important, it is not enough on its own to transform outcomes for children. That is why we expect the WWC to work in close partnership with the sector and bring new and innovative approaches to gathering, disseminating and embedding its findings, drawing on lessons from a wide range of interventions – including reviews of serious cases, the Innovation Programme and Partners in Practice. It will be a critical part of our plan to raise the status and quality of the social work profession, and in learning lessons from horrific cases of the past.

89. We have already started early market engagement and plan to commission the WWC over the next few months. **We expect to launch the new organisation at the end of the year.**

Chapter 4: Governance and accountability

In 'Children's social care reform: a vision for change' we set out our ambition to establish diverse and dynamic children's social care organisations; reform the arrangements across agencies for coordination and accountability of services and responsibilities for safeguarding children; and intervene swiftly and decisively to turn around failing organisations.

To achieve this, we will:

- encourage bids for Innovation Programme funding from areas interested in testing out a new delivery model for all or part of a children's social care service
- undertake a review of the role of the local authority in relation to children, including children's social care
- introduce new, more robust, flexible and proportionate inspection arrangements
- introduce a stronger statutory framework for multi-agency safeguarding arrangements, creating greater accountability for the three key agencies of health, police and the local authority
- intervene decisively in cases of failure, removing service control from any local authority which has persistently or systemically failed and does not have the immediate capacity to improve

90. Through the Innovation Programme and through Partners in Practice, we have begun to see some real excellence emerge in the provision of children's social care services. It remains the case, however, that there are too few examples of excellence and too many examples of failure or of organisations struggling to deliver strong services. Too often vulnerable children and families have not been the singular focus for how services are managed; innovation has not been given the space to thrive; data have not been used intelligently; leadership has not been strong enough; and services have not been delivered within a coherent and consistent framework, driving practice. Local authorities are also facing an increasingly constrained fiscal climate, seeing greater demand for services and dealing with new threats to children and young people.

91. All of this makes a clear case to do things differently. Structural solutions and stronger accountability have an important role to play in driving change. Our reforms in this area focus on: supporting the emergence of innovative organisational models for children's social care including Trusts and as a strategic priority within devolution deals; ensuring sharper and more focused accountability; and intervening decisively in cases of failure.

Supporting new organisational models

92. The current system, where the vast majority of children's social care services are delivered by in-house local authority teams, is not delivering consistently excellent practice. Local authorities are diverse in size and demography, but the structure for delivering services is much less diverse and governed by very many of the same rules whether in large cities and counties or in small unitaries. Whilst structural change is not an end in itself, in the right circumstances it may be the key to unlocking improvement and responding to budgetary pressures as well as new threats to our children and young people. New models can:

- refresh leadership and attract strong and ambitious people to organisations where new ways of doing things are needed
- attract good people more generally – including to areas where previous organisations have had a poor reputation and recruitment problems
- provide a sharper focus on children's social care as a whole or on aspects of the system
- enable existing strong organisations to innovate more easily and to create a distinctive culture of excellence
- bring together different areas and organisations in robust structures which go beyond collaboration and into integration

93. Over recent years we have seen two particular approaches emerge:

- new Trust arrangements – whereby children's social care functions are delegated to not-for-profit organisations separate from local authorities (though political accountability remains with the council). This can be achieved voluntarily, by local authorities seeking to pursue new ways of working, and has also been delivered

under direction from central government in cases of local authority failure, for example in Doncaster and Slough

- combined authorities[6] (including new sub-regional or city deal arrangements) – where local authorities come together in a variety of arrangements to operate some or all children's social care services across a larger geographical area. Again, this might happen voluntarily as innovative local authorities seek to drive change (e.g. Tri-borough in London); or as a result of local authority failure, with a high-performing local authority leading work to improve services in a failing authority (e.g. Hampshire leading work in the Isle of Wight)

94. It is, of course, possible to combine approaches. Richmond-upon-Thames and Kingston-upon-Thames voluntarily combined their children's services and created a new community interest company to deliver those services, Achieving for Children.

95. We have also seen that in specialist areas partnerships with strong national charities can help to transform service quality (for example, Coram in adoption) by offering a singular focus on and expertise in relation to children and families in need of that service. This can help a struggling part of the service to catch up, or can bring increased improvement capacity and expertise to one part of a wider improvement plan.

96. Evidence from the small number of existing alternative delivery models already in existence is very encouraging. We know already that some of the strongest local authorities and their partners are thinking creatively and boldly about how alternative delivery models could improve outcomes for children – making services better, more secure and effective in the future. By the end of this Parliament, the government anticipates that most local authorities will be in a devolution deal and we therefore expect to see a significant shift in the national picture of children's social care delivery

[6] Combined authorities are a legal structure that may be set up by two or more local authorities in England, with or without a directly-elected mayor. They may take on statutory functions transferred to them by an Order made by the Secretary of State, plus any functions that the constituent authorities agree to share. The relevant legislation is the Local Democracy, Economic Development and Construction Act 2009 and the Cities and Local Government Devolution Act 2016

with a mixed economy of delivery models. **Our ambition is that, by 2020, over a third of all current local authorities will either be delivering their children's services through a new model or be actively working towards a different model.**

97. In future we expect to see more children's services not-for-profit Trusts leading children's social care services in a single authority, or having the responsibility for all children's social care services in a combined authority area. It is also likely that we will see Trusts delivering a sub-set of children's social care services, for example, for leaving care services. In some areas combined authorities will commission services across wider areas and different kinds of services will operate across different areas, according to what works best to improve outcomes for children and families. We intend no change in the current legal arrangements which prevent local authorities from delegating their functions to profit making organisations.

98. Areas of focus for combined services might include:

- establishing centres of excellence for specialist teams and services operating across groups of local authorities or Trusts (for example, leaving care teams, disabled children's teams, or for children with the most complex needs)
- creating joined-up commissioning arrangements – for residential care and fostering
- ensuring clearer lines of accountability and strong leadership: this might include a single leadership structure for several authorities or Trusts, controlling a single budget
- developing better structures for working with partner agencies, based on a closer alignment of boundaries
- creating workforce development programmes that operate across boundaries
- forming strategic partnerships with voluntary and community sector organisations, drawing on their specialist expertise to deliver services

Case study

Greater Manchester Combined Authority (GMCA) has set a vision to achieve the best outcomes and life chances for children and their families across Greater Manchester (GM) and to build a system that works for families and delivers the same high quality support regardless of traditional boundaries across the city. In 2015, GMCA began a fundamental review of its children's services including a comprehensive service mapping, analysis of data and cost comparisons. This has resulted in a set of recommendations for how we want to organise and govern children's services across GM in the future. For the GMCA and each of ten councils this means we will have collective responsibility and accountability for our children and young people and we will have an agreed set of standards and performance metrics to monitor our practice and our progress. Our services will be governed and run at either a combined authority level; via a Greater Manchester centre of excellence led by a specific authority; at a locality level; or commissioned via the GMCA, depending on the type of provision.

99. We are particularly interested in testing specialist Care Leavers Trusts – new organisations that would be focused entirely on improving the life chances of care leavers (aged 16-25), putting the care leaver at the centre and better providing them with the holistic, all round support they need.

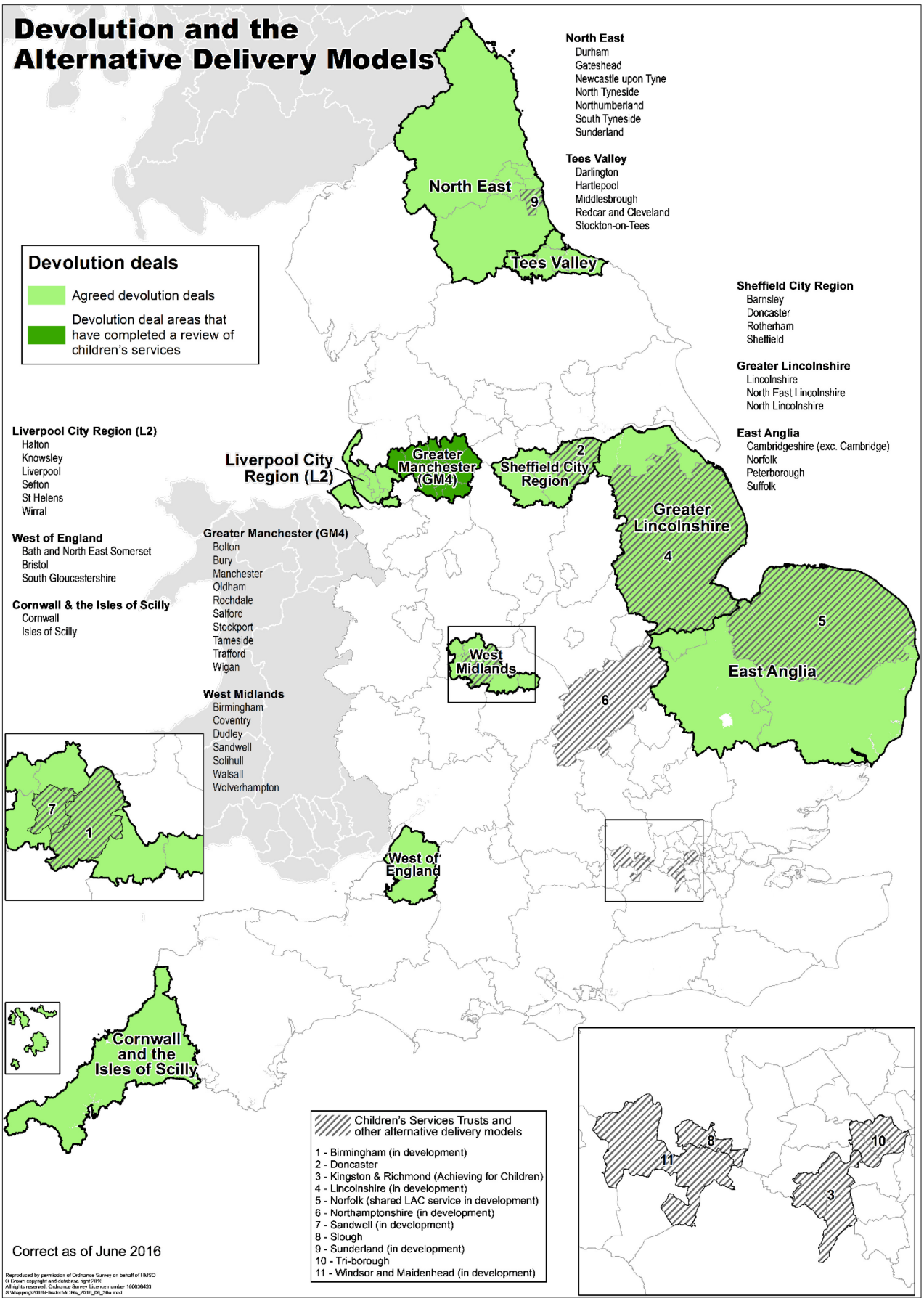
100. Local authorities are also coming together with voluntary adoption agencies to form larger Regional Adoption Agencies to improve outcomes and practice. The government currently supports 19 proposed Regional Adoption Agencies, all of which have made progress in recent months towards defining the role of the new regional structure and built partnership arrangements between local authorities and the voluntary sector to deliver services. Through increased and more effective co-operation within regions and across boundaries, Regional Adoption Agencies will help maximise children's chances to find an adoptive family and improve outcomes. They will also provide an opportunity to share existing good practice between local authorities and the voluntary sector and develop innovate working practices. The views of adopters and children have helped shape the service design with a view to improve their experience under the new system.

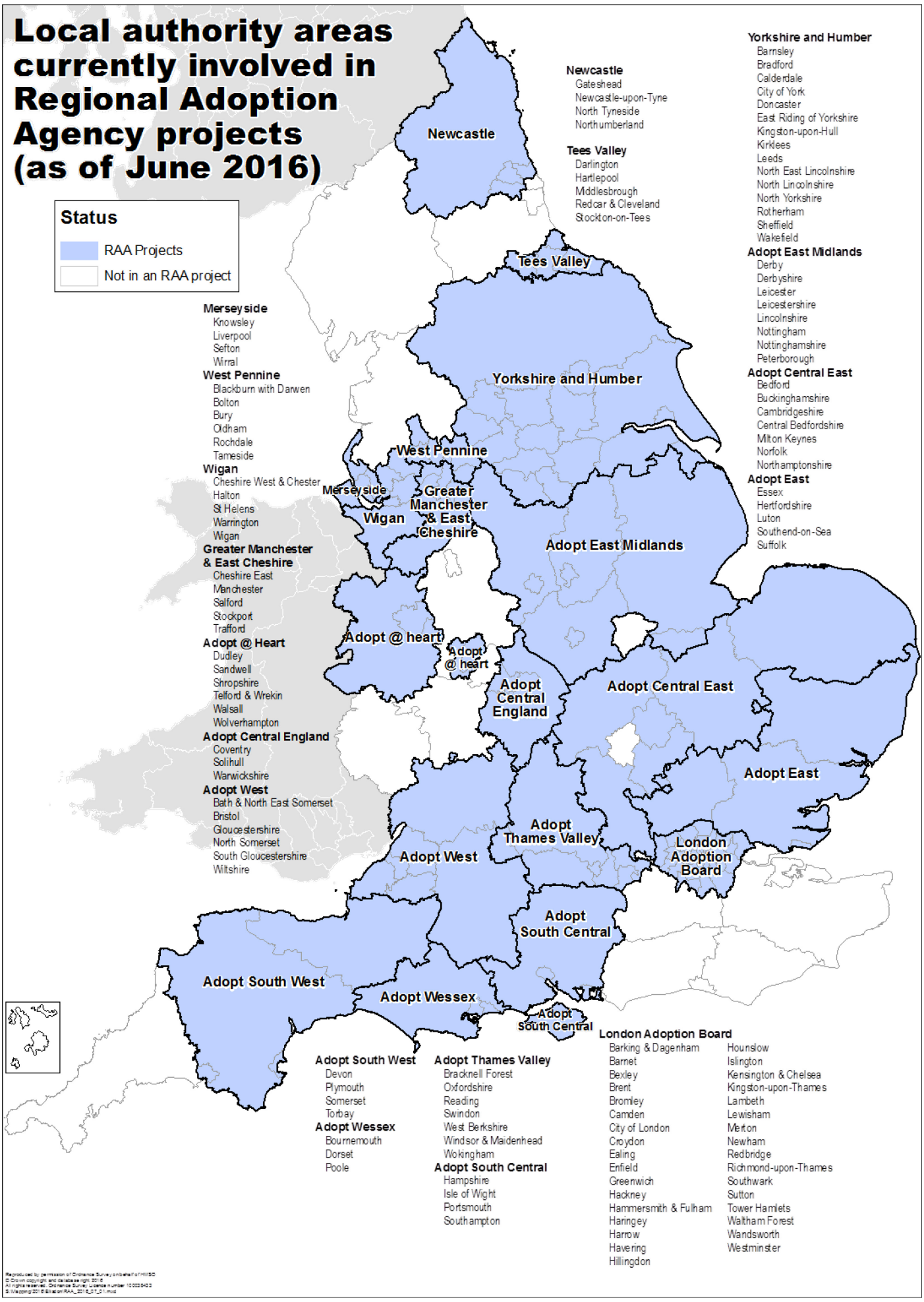
101. It is likely that there will be variable geography in how services are delivered across England and that not all boundaries will be co-terminus with existing arrangements. Whilst this might not offer the one size fits all simplicity that it is tempting to apply from Whitehall, the important thing is that each area offers the right services for their particular children and families, and that those services are run to suit the needs of each area.

102. In working through these steps authorities need to be ambitious – to think creatively and act boldly to secure excellence – ensuring that their services are the best possible fit for their local area. We want to encourage all areas to open up a dialogue with local partners and to scrutinise and review services – not to feel constrained by historical divisions and practices.

103. To support these ambitions, we will:

- encourage more bids on alternative delivery models for the next round of the Innovation Programme and provide access to expertise in policy and change management approaches to those areas that are developing proposals for new models
- co-design approaches with each devolved region and provide support in sharing best practice through networks, communications and support
- de-regulate where there are barriers
- help to tailor a children's social care element to each devolution deal to match the local landscape and to pull in engagement across government where needed
- work with Ofsted to develop a model of inspection that works with services operating in different geographical areas and under different models of governance, including combined authorities
- offer support to broker and form strategic partnerships with VCS organisations, particularly as part of a Trust arrangement
- work closely with Regional Adoption Agency projects to understand and address the challenges they face and help to ensure they will bring about real practice improvements




Local authority areas currently involved in Regional Adoption Agency projects (as of June 2016)
Status
RAA Projects
Not in an RAA project
Newcastle
Tees Valley
Yorkshire and Humber
West Pennine
Merseyside
Wigan
Greater Manchester & East Cheshire
Adopt East Midlands
Adopt @ heart
Adopt @ heart
Adopt Central England
Adopt Central East
Adopt East
Adopt Thames Valley
London Adoption Board
Adopt West
Adopt South Central
Adopt South West
Adopt Wessex
Adopt South Central
Newcastle
Gateshead
Newcastle-upon-Tyne
North Tyneside
Northumberland
Tees Valley
Darlington
Hartlepool
Middlesbrough
Redcar & Cleveland
Stockton-on-Tees
Yorkshire and Humber
Barnsley
Bradford
Calderdale
City of York
Doncaster
East Riding of Yorkshire
Kingston-upon-Hull
Kirklees
Leeds
North East Lincolnshire
North Lincolnshire
North Yorkshire
Rotherham
Sheffield
Wakefield
Adopt East Midlands
Derby
Derbyshire
Leicester
Leicestershire
Lincolnshire
Nottingham
Nottinghamshire
Peterborough
Adopt Central East
Bedford
Buckinghamshire
Cambridgeshire
Central Bedfordshire
Milton Keynes
Norfolk
Northamptonshire
Adopt East
Essex
Hertfordshire
Luton
Southend-on-Sea
Suffolk
Merseyside
Knowsley
Liverpool
Sefton
Wirral
West Pennine
Blackburn with Darwen
Bolton
Bury
Oldham
Rochdale
Tameside
Wigan
Cheshire West & Chester
Halton
St Helens
Warrington
Wigan
Greater Manchester & East Cheshire
Cheshire East
Manchester
Salford
Stockport
Trafford
Adopt @ Heart
Dudley
Sandwell
Shropshire
Telford & Wrekin
Walsall
Wolverhampton
Adopt Central England
Coventry
Solihull
Warwickshire
Adopt West
Bath & North East Somerset
Bristol
Gloucestershire
North Somerset
South Gloucestershire
Wiltshire
Adopt South West
Devon
Plymouth
Somerset
Torbay
Adopt Wessex
Bournemouth
Dorset
Poole
Adopt Thames Valley
Bracknell Forest
Oxfordshire
Reading
Swindon
West Berkshire
Windsor & Maidenhead
Wokingham
Adopt South Central
Hampshire
Isle of Wight
Portsmouth
Southampton
London Adoption Board
Barking & Dagenham
Barnet
Bexley
Brent
Bromley
Camden
City of London
Croydon
Ealing
Enfield
Greenwich
Hackney
Hammersmith & Fulham
Haringey
Harrow
Havering
Hillingdon
Hounslow
Islington
Kensington & Chelsea
Kingston-upon-Thames
Lambeth
Lewisham
Merton
Newham
Redbridge
Richmond-upon-Thames
Southwark
Sutton
Tower Hamlets
Waltham Forest
Wandsworth
Westminster

Regional commissioning of residential care placements

104. Regional arrangements are also of potentially significant benefit when it comes to commissioning residential care placements. Skilled commissioning plays a vital role in ensuring that residential care placements of the right type, quality and price are available and can be readily accessed when children need them. Over recent years, the large majority of local authorities have chosen to commission their fostering and residential care services collaboratively, recognising the potential for savings, wider placement choice, and therefore better outcomes for children.

105. But Sir Martin Narey's detailed look at commissioning as part of his review of residential care indicates that the current collaborative arrangements are not delivering anything like the cost and quality benefits, the increased placement choice or the impact on children's outcomes that they could.

106. We agree with Sir Martin that better commissioning practice – including a more intelligent use of block and cost and volume contracts – will ensure better value for money for local authorities and improved confidence for providers.

107. We also agree with Sir Martin that organising commissioning on a larger, regional scale is key. Children's care needs are changing and diversifying, and local authorities need to come together to shape the market and provide a wide range of placement options if they are to put children's needs first. A regional approach will better ensure local authorities find the best placement for each child, and always make informed decisions about where to place them – going out of area where this is the right thing for the child rather than because there is no alternative. Commissioning on a much larger scale could play an important role in extending placement choice, improving quality and meaning children get the support they need, when and where they need it.

108. To help drive this forward, and as part of the new round of Innovation Programme funding covered earlier, we will invite local authorities to come together to bid to pilot new, larger scale commissioning arrangements that will test the options for wider placement choice, better value for money, greater confidence for providers and better outcomes for children.

109. For secure homes, the government has signalled its wish to see a more co-ordinated approach to planning and placements. We are already funding a central co-ordination unit which is collecting data to enable us to test whether a move to central commissioning would provide better support to this most vulnerable group of looked after children.

Reviewing the role of the local authority

110. The White Paper, 'Educational Excellence Everywhere', set out a radical vision for the full academisation of the schools system. Local authorities will continue to play a positive and important role in the reformed system, but it will clearly be a changing role. The White Paper made a commitment to review the responsibilities of local authorities in relation to children, including implications for the roles of the Director of Children's Services and the Lead Member for Children. As children's social care is already the largest role local authorities play in relation to children, it is important that the review looks at the implications of changes in relation to schools for the social care system. The review will consider three broad questions:

- what the future role and responsibilities of the local authority in relation to children and young people should be
- what powers and levers local authorities will need to carry out those responsibilities effectively
- what transition and implementation arrangements will be needed to help local authorities manage change over the coming months and years

111. Talking to local partners will be key, both informally and through an advisory board to test key findings. Alan Wood CBE, former Chief Executive of the Learning Trust, will chair this advisory group.

Ensuring robust and proportionate inspection

112. Ofsted's current Single Inspection Framework (SIF) provides a comprehensive baseline of local authority performance in children's social care. Its focus on practice has moved the quality of debate forward significantly and provided a robust basis for identifying and addressing poor performance.

113. The SIF was introduced in November 2013, bringing together previously separate inspections. All local authorities will have been inspected under the SIF by the time the cycle is completed at the end of 2017. Its detailed and intensive approach means, however, that the inspection process can be burdensome for frontline services and is not able to respond effectively to changing circumstances.

114. **Ofsted is now consulting on the principles of the next inspection framework, and will be consulting on the detailed content later in the year.** Ofsted intend to move towards a new inspection regime that will act as an enabler for excellent social work practice and innovation. Having secured a clear baseline of performance across all local authorities the future regime will take a more proportionate, more dynamic approach, with shorter, sharper and more frequent inspections. This will allow high performing councils the space to get on with the job, and free up the inspectorate to spot failure sooner in areas of concern. Modular inspections would underpin a more targeted approach to supporting local authorities in getting to good and, equally, where early signs of deterioration in performance in a good authority are detected, identifying where the local authority needs to focus its attention to maintain a good judgement.

115. Alongside its inspection activity, Ofsted's regional structures and systems provide good access to local intelligence and data about council performance in children's services and a channel for discussing innovative approaches and good practice. Under the proposals which Ofsted is consulting on, this local information will support decisions about the timing of inspections and underpin a greater understanding of the issues and challenges facing individual local authorities.

Using joint targeted inspections to drive improvement

116. Recognising that safeguarding children is the responsibility of a range of agencies Ofsted has now also commenced its initial round of joint targeted area inspections, alongside inspectorates for the constabulary, probation and health. Under this approach, a joint inspection team looks together at the experiences of children and young people in the local area, with a focus on how agencies work with each other to safeguard children. In addition, the review teams will be looking at leadership and management, and the influence of the Local Safeguarding Children Board.

117. The focus of the first round of inspections is child sexual exploitation and children missing from home, care and education and a comprehensive report will be published in September setting out findings and highlighting good practice across the sector. A second round will commence in the autumn with a focus on children living with domestic abuse.

Improving multi-agency working

118. The review by Alan Wood CBE of the role and functions of Local Safeguarding Children Boards (LSCBs) was published in May, together with the government's response. Alan consulted extensively during his review and found a clear consensus in favour of reform. As a result, we are seeking to introduce a stronger statutory framework which will introduce greater accountability on the three key agencies involved in safeguarding children, namely local authorities, the police and the health service. As well as being stronger, the arrangements will be more flexible and enable local areas to determine the best way to organise themselves. There will be no obligation to have a Local Safeguarding Children Board, if local areas can develop more effective arrangements.

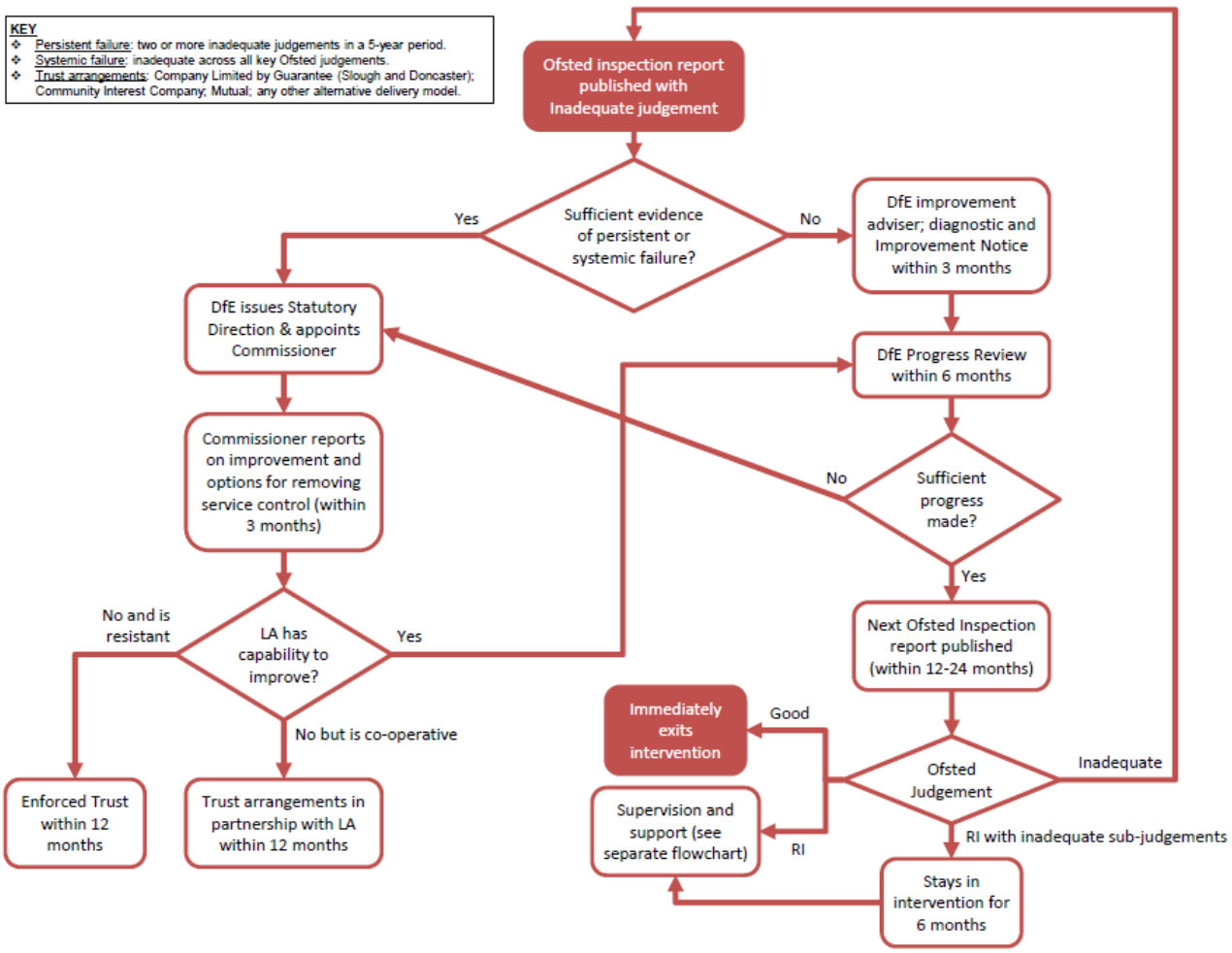
119. The proposed new local arrangements will put a duty on the three key agencies to work together to safeguard and promote the welfare of children, and jointly identify and respond to emerging needs and priorities. They will also be required to produce and publish a plan which will set out how they will carry out this duty. They will need to decide, among other things, how they will work with other agencies, what the resourcing for the arrangements will be, how to share information and data, and how they will ensure there is independent scrutiny of their decisions. They will also be responsible for undertaking local child safeguarding practice reviews. Some details will be included in associated regulations, and there will be statutory guidance to support the agencies. We will consult on the regulations and statutory guidance in due course.

Intervening strongly in cases of failure

120. Keeping children safe is one of the most important things councils do, but one in four recent Ofsted reports shows councils failing to deliver adequate children's social care services. The government will take whatever action is required to ensure children receive the services they deserve.

121. We are strengthening our approach to intervening when councils fail to provide adequate services for children in need of help and protection, children looked after, or care leavers as follows:

- whenever Ofsted finds children's social care services to be inadequate, we will provide expert scrutiny to diagnose problems and support the council to produce an effective improvement plan within three months
- we would expect most of those councils to improve with support and challenge from experts, but councils' progress towards improvement will be reviewed every six months
- if these reviews find that insufficient progress has been made, we will appoint a children's services Commissioner to review whether services should be removed from council control
- we will also immediately appoint a Commissioner wherever council failure is systemic, with a presumption that the service will be placed outside of the council's control, unless the Commissioner identifies good reasons not to do so, and where we judge that failure has become persistent we will take the same approach
- where councils do not have the capacity or capability to improve children's social care services in a reasonable timeframe, we will remove those services from council control for a period of time and transfer them to a different organisation (usually a Trust) in order to secure sustainable improvement



Supporting improvements through Trust delivery arrangements

122. There are often three main challenges which lead to a failure to turn services around. Firstly, some local authorities, through poor political or officer leadership, are unable to turn around poorly performing services, even over a long period of time. Secondly, the size of the improvement task has sometimes seemed too large for one organisation, resulting in one area of work improving while another falls back, or in ineffectual progress across the piece. Thirdly, insufficient capacity can mean that concentration on the basics cannot be combined with innovation. Putting in place a Trust in these circumstances can provide fresh leadership, additional improvement capacity, clarity of purpose and a more stable operating environment.

123. We have done this already in Doncaster and Slough by setting up new independent children's social care Trusts and we are already seeing signs that the new Trusts in these areas are beginning to have a positive impact. The Trusts mark a new stage in innovation and improvement for the children, families and social workers in these areas.

124. This chance for a fresh start is one that we are keen to offer to more councils that are struggling to deliver effective children's services and recognise that they need to try a different approach. We have been working collaboratively with Sunderland City Council to establish a voluntary Trust there that is similar in design to Achieving for Children (Richmond and Kingston) and will take over delivery of children's services there from April 2017. We are also working with Birmingham and a number of other councils to establish whether voluntary Trusts are the best option for rapidly accelerating improvements to children's social care services in those areas.

Investing in improvement, supervision and support

125. Driving improvement in children's social care services needs to be locally led and delivered to meet the needs of our different communities and of individual children and families. Each local area has a clear responsibility to its own children and families. The role of central government is to intervene in cases of failure, and to create a national infrastructure which enables and supports the pursuit of excellence and innovation. But that should not detract from the core, local responsibility for effectively helping and supporting local children.

126. Those councils that are not failing but still require improvement to be good can access support to do so through the sector-led support offers from the Local Government Association and the Association of Directors of Children's Services, who have an important role to play in driving continuous improvement in children's services. ADCS are, for example, planning to publish shortly a set of key "must do's" that need to inform any successful improvement journey. More generally, ADCS regional arrangements will continue to be key to improvement and to spreading best practice.

127. At a national level, central government will support sector led innovation through our Innovation Programme as well as through the reforms to the Ofsted inspection regime. We will also help to embed peer-to-peer learning, make success replicable and drive improvement across the social care system by working with our Partners in Practice and investing in the What Works Centre. The Local Government Association's peer review system and work for their Children's

Improvement Board will operate alongside these approaches and we will work together to ensure we complement one another.

128. Where Ofsted returns a “requires improvement” judgement on a previously inadequate council, central government will continue to provide supervision and support for 12 months to ensure that improvements are sustained. We will also place those councils, whose adoption and care leavers’ services are inadequate, under supervision and provide them with support to improve rapidly.

129. Over time, we would want the balance of government activity to shift away from intervening where there is failure, towards supporting the spread of excellence, in a system which is more likely to challenge us to enable innovation than to seek our support to improve.

Chapter 5: Putting the three pillars into action: how will things change for children and families?

130. This paper has set out an action plan for building the 'three pillars' of reform which we think are critical in a social care system that puts children first. By focusing on these three fundamental building blocks, we hope to transform the experiences of children and families across every stage of their journey through the social care system.

131. For individual children and families, this will mean consistently getting support from practitioners who know how to make real, lasting change happen – to make real change in the course of children's lives, rather than watching, waiting and monitoring. It will mean getting support from a system designed entirely around putting children first, however complex their needs.

132. This chapter sets out some of the ways in which our reforms will change and improve the real-life experiences of children and families, bringing about sustainable change and stability in their lives, and placing strong relationships back at the heart of the system.

Putting children first is everyone's responsibility

133. All agencies locally – schools, the police, health services, youth services – need to understand and buy into the local arrangements for identifying children at risk and putting in place an appropriate response. This is the key ingredient to ensuring that issues are identified and appropriate referrals made to children's social care. The strengthened multi-agency arrangements which will replace LSCBs are intended to drive greater levels of partnership and more bespoke arrangements for identifying problems and responding to them.

134. There is of course a role for the wider public too, in spotting and sharing concerns about children at risk. We know that people are often cautious about alerting social care to their worries about children or families, because they don't feel confident to interpret what they've seen or the consequences of making a referral. The government's new communications campaign "Together we can tackle child

abuse" is designed to help tackle these worries. It was launched earlier this year and **we will run the campaign again in 2017.**

135. The role for the wider public does not stop when a vulnerable child turns 18. Just as other young people continue to receive support from their parents into their twenties and beyond, children who are looked after and supported by the state continue to need help and guidance. To offer this support to young people leaving care, **we are introducing a new voluntary care leaver covenant that organisations can sign up to and make a commitment to support care leavers**. The covenant will provide an opportunity for private organisations, charitable bodies and central government departments to set out the services and support that they will offer to care leavers to ensure that the state continues to support them as they transition into adulthood. We will be engaging with relevant partners over the summer with an intention to launch the covenant in the autumn.

Providing help to prevent children needing to enter the child protection system

136. We are very clear that the children's social care system is there to provide help and protection to children facing acute social need and risk, or who are disabled – children for whom the state has a moral and legal responsibility to provide additional support and protection.

137. However, it is also important to ensure that help isn't only available when problems have escalated to the extent that state intervention is inevitable. Since the publication of the Munro Review, many local authorities have developed their 'early help' offer to families, and work closely with schools, health services and others to provide holistic support to children and families as soon as a need emerges. But despite this, we are not seeing a reduction in the number of referrals to children's social care, and *are* seeing a significant increase in the number of families needing the most intensive forms of intervention through child protection plans – up by 27% since the data collection began six years ago.

138. This raises questions about whether the early help currently on offer to children on the edge of the social care system is really working to address their problems. We cannot leave these children and their families to languish until the conditions of

some of them deteriorate to the point that intervention from the state in their lives is inevitable. We see the provision of targeted early support in these circumstances – clearly distinct from broader, more universal early help – as an area where we have not yet determined the right, most effective role for children's social care.

139. The Troubled Families Programme is undoubtedly one programme already adding to our understanding of what works to support complex families to secure better life chances for themselves and for their children, to avoid the need for children's social care to get involved, and to break the cycle of disadvantage, in particular through getting parents into work. The Programme continues to be a key plank of the government's life chances agenda, and will increase its focus on improving parenting, family stability and ensuring pre-school children within the Troubled Families cohort are meeting child development milestones. Some local authorities have brought together their Troubled Families and Early Help services to form one coherent support offer.

140. However, the focus of the Troubled Families programme is not specifically children in or on the edge of needing children's social care services; it works with a broader range of families. Finding out what will work to effectively reduce need and risk for the specific group of children right on the edge or just within children's social care, and what the role of children's social care should be for these children, is exactly the kind of thing our new national learning infrastructure is designed to investigate. **We will work with our Partners in Practice local authorities and use the Innovation Programme to test and develop national understanding, and over time will use the new What Works Centre to bring together learning and spread best practice.**

Helping children within the child protection system

141. As well as investigating new ways of working with those children at the very edge of, and just within, children's social care, we need to rethink practice in relation to children within the child protection system facing the most serious needs and risks. If we are to effectively support families where children are already at risk of harm, and make genuine and sustained changes to their lives, this will require effective

and sustained interventions. We need not to withdraw services at the first sign of improvement.

142. We need to deepen our understanding of how best to support families facing such entrenched challenges to become stronger, through skilled assessment of parental capacity and sustained intervention. We need to know how to draw more effectively on family strengths and resilience, and on support from wider social and community networks. We need to develop ways of working with families where children are at risk of harm which enable them to work together with professionals to quickly reduce immediate risks and work out long term strategies for changing their lives more fundamentally. We also need to build on and test emerging evidence which suggests that the longer a child is kept on a child protection plan, the more improvement we see in their outcomes.

143. Identifying the sorts of interventions that really work to make lasting change happen for children on child protection plans – and prevent the need for children to become looked after – **will be a key focus for the Partners in Practice local authorities, Innovation Programme and What Works Centre**.

A safe and stable home for every child

144. Where a child's birth family cannot meet their needs, it is the role of the children's social care system to create the safe, stable and nurturing relationships and home environment that children need, whether through adoption, foster care, family and friends care or residential care. For these children, the state becomes their 'corporate parent'. In recognition of the gravity and importance of this role we are currently legislating to set out in law, for the first time a set of 'corporate parenting principles', which will guide the way in which the whole local authority – not just children's social care – acts as any good parent would for children in care and care leavers.

145. Our success in finding safe, stable homes for all children who need them has improved in recent years. Children are now finding permanence through adoption four months more quickly than they were in 2012-13; three quarters of residential homes are now rated 'good' or 'outstanding' by Ofsted; and we have funded councils to find new ways to attract and retain foster carers from a broad range of

backgrounds. But we still see too much instability in placements for looked after children, including for disabled children, and too much of a focus on making a single placement decision which works right now, rather than really working out what is needed to meet the complex and evolving needs of a particular child for the long term.

Foster placements that work

146. Some local authorities are better than others at matching the right child with the right placement to fully meet their needs, now and for the long term. Early findings from some of the projects that have been funded through the Innovation Programme, such as North Yorkshire's No Wrong Door programme and the Mockingbird programme, have started to show us how stability in a family environment can be achieved even for children with the most challenging backgrounds when foster carers are properly trained and supported, and young people have access to proper respite and therapy. We will use the new national learning infrastructure we are putting in place to learn from the best authorities and providers. In addition, **we will undertake a national stocktake of foster care to give us a richer understanding of how placements are made**. This will have as its central focus the question of what different foster carers need – skills, expertise, support – in order to meet the diverse needs of today's looked after children.

Extract from Sir Martin Narey's review of residential care in England, July 2016

"Although fostering does not seem to work for some children, particularly adolescents, I believe that residential care can sometimes be used to make fostering a success, even when it might have failed previously. And evidence suggests this can be achieved with the most challenging of older children – those who might be very resistant to the notion of being fostered – as demonstrated by the excellent No Wrong Door (NWD) initiative in North Yorkshire.

"Two children's homes in this geographically vast county act as hubs. Each hub provides placements in mainstream residential care; emergency beds; community foster family placements; supported accommodation and supported lodgings with outreach support. Children often move from one type of placement to another, but the key element of the NWD approach is ensuring that each adolescent has one key worker who works with him or her throughout. The quality of residential care provided in North Yorkshire is of exceptional quality (one of the two hubs had a full Ofsted inspection as I was completing this report) and the Ofsted commentary – alongside the Outstanding rating - is remarkably positive."

Jaden*, Essex

Used with permission from St Christopher's Fellowship

The role of residential care

147. Sir Martin Narey's review shows us that residential care remains an important part of the care system. His report reminds us that, for some children, a residential care home is absolutely the right place for them – either to manage a crisis or, in the short term, to provide intensive support and help prepare them for moving into a family home as part of a fostering arrangement. And, for some children, residential care is their best long term option.

148. Sir Martin's report highlights a number of ways in which residential care could be used in a more dynamic and creative way to support children – as we see in excellent projects such as No Wrong Door. We therefore intend to introduce a specific stream of the Innovation Programme to test these ideas and take to scale those that have already shown their effectiveness through the first stage of the programme.

> "When I first moved to the children's home I did not like it. It was hard having all the people. It taught me about respect for other people and this has been really helpful for me in everything I do. Some of the people have become my best friends and I have just moved into a shared house with one of them. Living in a children's home helped me achieve my goals and they helped me learn to cook and budget and so I was ready to leave. Even though it was very different to being in a family home, I felt cared for and I made proper relationships while I was there. It was a big part of my life and made me who I am."
>
> **Craig*, 19**

Sir Martin Narey's review of residential care – the government's initial response

We are hugely grateful to Sir Martin Narey for his insightful report and for the significant contribution it makes to our understanding of children's homes in England. We are pleased that he has concluded that the quality of the care they provide – to some of our most vulnerable children – is often very good and that residential care is the right placement choice for some children, not a last resort.

We accept his analysis and findings and welcome the recommendations that Sir Martin has made and which highlight the areas where further action is needed to ensure that all children's homes, and the wider system in which they operate, deliver the highest quality care. We will respond more fully in the autumn. However, some immediate actions are clear and we will take them forward now:

- we will use the Innovation Programme to test innovative ways in which residential care could be used in a more dynamic and creative way to support children and to link seamlessly with other care placements and with other services
- we are committed to introducing Staying Close for those leaving residential care – similar to the Staying Put arrangements which exist for children in foster care. We are going to pilot variations of the scheme, through opening a specific stream of the Innovation Programme, in order to understand the costings, practicalities and impact first
- we will invite local authorities to come together to bid through a new round of Innovation Programme funding, to pilot new larger scale, regional commissioning arrangements that will test the options for wider placement choice and better outcomes for children
- we will undertake a national stocktake of foster care to better understand current provision, how needs are matched with skills, where this works really well, and what can be learned nationally from good practice
- we will clarify the steps that residential care workers can take to protect children, as any good parent would

A new, permanent family for every child who needs it

149. ‘Adoption: a vision for change’, published in March 2016, sets out the government’s plans for a radical redesign of the adoption system. In line with our wider strategy for children’s social care, our plan for adoption is to create the workforce, practice systems and delivery structures needed to provide a permanent home through adoption for every child whose interests are best served by this. Our professional development programme ‘Achieving Permanence’ will provide adoption social workers with the specialist skills they need for this area of work; our adoption-specific Practice and Improvement Fund will stimulate the spread of excellent practice on the front line; and our plan to regionalise the adoption system will mean services are delivered on a scale and in a way which will better serve the needs of children and adopters.

Supporting and empowering carers to care

150. In order to settle and prosper, and achieve real stability in their lives, children need, above all else, the backing of strong, consistent and resilient relationships they can depend on. That is why we will consider with Partners in Practice the legislation, regulation and guidance which underpins work with looked after children and care leavers, to identify where greater freedom and flexibility will help put relationships at the centre of practice. It is vital that foster carers have the freedom to care, and the delegated authority to make day to day decisions for the children in their care. We want foster carers to be actively involved in decisions about the children they are looking after, for example in relation to their schooling, agreeing the additional support they need, and decisions about care planning. We want to empower foster carers to stand up for and look out for the children they look after as any good parent would.

151. Sir Martin Narey’s report also reminds us that, just as foster carers sometimes feel unable to make day to day decisions on behalf of the children in their care, staff in children’s homes sometimes feel unable to take the kind of action to protect children that any good parent would take when putting the needs of their child first. Day to day acts, such as setting curfews or locking the doors at night, are exactly the sorts of things that good carers do. Setting boundaries is one of the most important tasks of a parent.

152. Building on Sir Martin's recommendation to strengthen the government's guidance, we want to make sure that all those who look after children in care have, and feel that they have, the power to parent. They need to feel confident and able to act decisively when protecting children from risks – as any parent would. It is a legally complex area, and it is critical that we maintain all the current safeguards which prevent any abuse of power by adults in a caring role. But **to provide more certainty for carers and to give them the power to parent, we will take the best and most up-to-date advice from experts to create practical advice and guidance for residential care workers.**

153. Adoptive parents and special guardians need support to nurture resilient relationships with their children and to meet their often complex needs. This support has been in place since May 2015 for adoptive families through the Adoption Support Fund (ASF) which has supported almost 7,000 families with over £23 million of therapeutic support. From 1 April 2016, in recognition of the often similar challenges these children and their carers face, the ASF was extended to families where the child left care through a Special Guardianship Order.

154. 'Adoption: a vision for change' set out our intention to continue strengthening the evidence base of 'what works' in terms of preventive and therapeutic adoption support. In the short term, this involves consulting with and securing views from a wide group of experts to inform proposals for commissioning research. In the longer term, the What Works Centre for children's social care will become the repository for this learning.

Safety, stability and relationships to depend on into adulthood

155. The need for nurturing, consistent relationships does not stop at age 18. As will be set out in more detail in our forthcoming Care Leavers Strategy, we need to apply the very same principles of reform to support for care leavers as we are to the rest of the children's social care system. Every young person needs a foundation of safe, stable and nurturing relationships in order to have the resilience to cope with the challenges life will throw at them, and thrive.

156. When a young person leaves care they continue to receive support from a local authority personal adviser who helps them to make a successful transition to

adulthood and independence through providing advice and identifying the support the young person needs. We will carry out a review of the role to better understand how personal advisers spend their time and identify ways to maximise the support that personal advisers offer the young people they are working with. Through the Children and Social Work Bill, we are extending personal adviser support to all care leavers up to the age of 25. But we are also keen to test out approaches that look beyond the personal adviser model, drawing on other sources of support so that care leavers have a wider, more resilient support network around them.

157. We also recognise that, whilst young people in foster care can now 'Stay Put' in their placement to age 21, there is still too much of a cliff edge for children in residential care. In response to Sir Martin Narey's specific recommendation, we are committed to introducing Staying Close for young people leaving residential care. Staying Close – similar to the Staying Put arrangements which exist for children in foster care – will enable young people to live independently, in a location close to their children's home with ongoing support from that home. As Sir Martin recommends we are going to pilot variations of the scheme, through opening a specific stream of the Innovation Programme, in order to understand the costings, practicalities and impact first.

158. Finally, we will look to free up local authorities to deliver services in new ways and in partnership with the voluntary sector, such as through testing specialist Care Leavers Trusts – new organisations that would be focused entirely on improving the life chances of care leavers aged 16-25, putting the care leaver at the centre and better providing them with the holistic, all round support they need.

Chapter 6: Our vision for the future

159. We want families to have more confidence in turning to professionals for help; for the help and protection we provide to be timely, enduring, flexible and thoughtful. We want families to work with professionals to quickly reduce immediate risks and work out long term strategies for changing their lives more fundamentally. Families will be supported to think through the impact of what happens now and to be made central to planning the future together.

160. We want every local children's social care service in England to have a workforce – at every level – with the knowledge and skills to do this highly challenging work to the highest possible standards. This needs to be verified through robust assessment and accreditation. The social work qualification must have credibility and mean professionals are equipped to deal with complicated situations and the highest levels of risk while striving for the best standards of practice.

161. We want those who care for children – foster carers, residential care home staff – to have the freedom to make decisions on behalf of the children in their care, and the power to parent in the way any good parent would. We want those who care to have the support and specialist skills they need to love and nurture our most vulnerable children.

162. To support this innovation and drive for excellence, by 2020 we want to see a more diverse range of children's social care organisations, operating over new geographical areas, supported by meaningful data and an inspection regime that supports high-quality evidence-based front line practice, with strongly supportive partners and local arrangements that best support coordination across agencies. And crucially, the performance of these new organisations must be driven by challenging, sharp and practice-focused accountability.

163. The future we want to see is one where excellent professionals do not shape their practice purely to comply with legal requirements, or guidance from Whitehall, but rather they form a confident profession, resilient when faced with new challenges, mindful of the role our society asks them to play in people's lives, and prepared to

learn from each other and redefine what works when ideas are tested and evidence is shared and understood.

164. Making this vision a reality is what it means to put children first.

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Appendix 4

Draft children's services improvement framework

Programme

Croydon children's services improvement programme

Vision

'Children and young people in Croydon will be safe, healthy, happy, and will aspire to be the best they can be. The future is theirs.'

Conditions

Croydon's conditions for success (see next page)

Key themes 'the three P's'
(for simplicity around communication)

People
Strong workforce and partnerships

Practice
Consistent, high quality social work

Performance
Support and challenge to improve children's outcomes

Improvement areas

The experiences, wishes and feelings of children and young people

- Leadership and governance
- Strong and skilled workforce
- Croydon Safeguarding Children Board
- Early help and the front door
- Children in need of protection
- Looked after childen and care leavers
- Fostering and kinship
- Adoption
- Vulnerable/high risk adolescents
- Management oversight and quality assurance
- Strategic commissioning

Systems and support that allow social work to flourish

Croydon's conditions for success