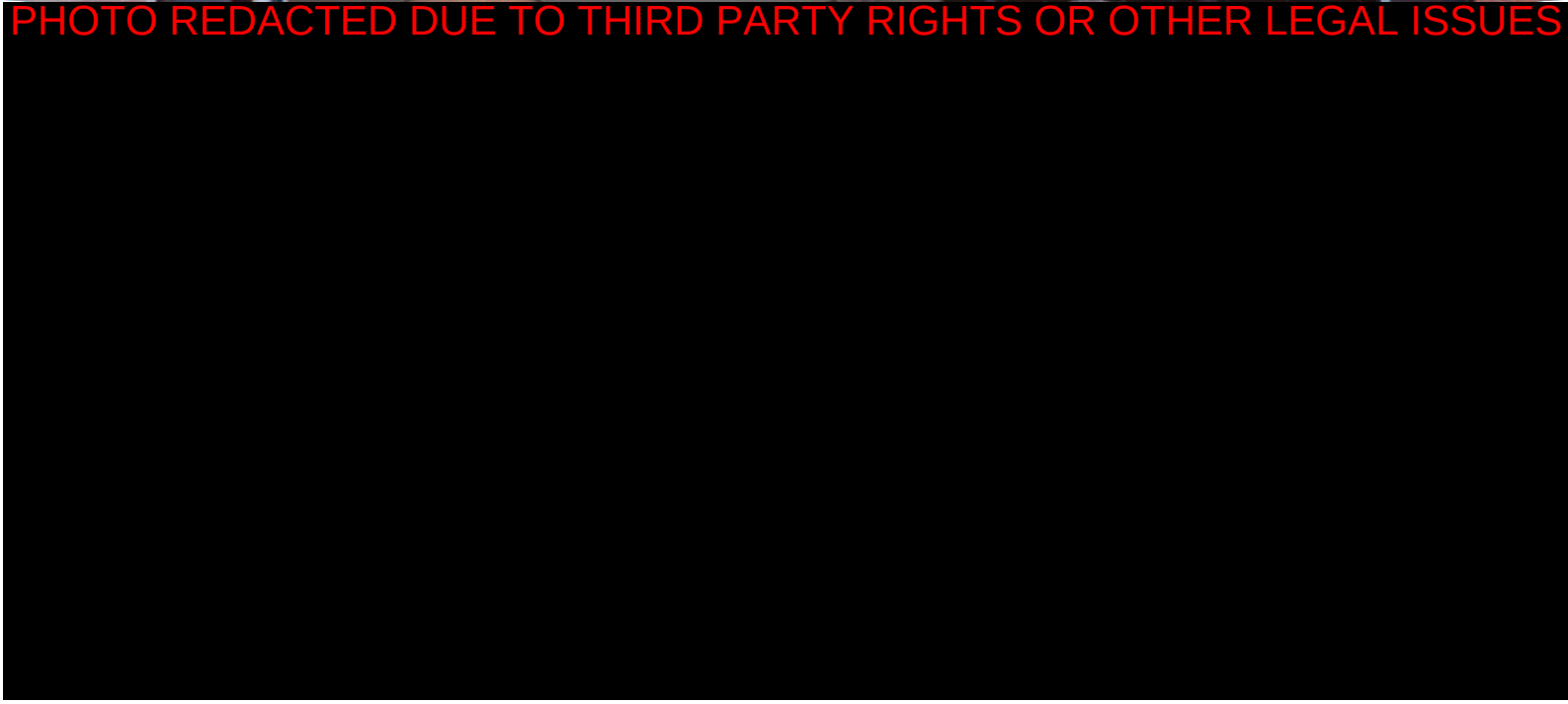

Ofsted
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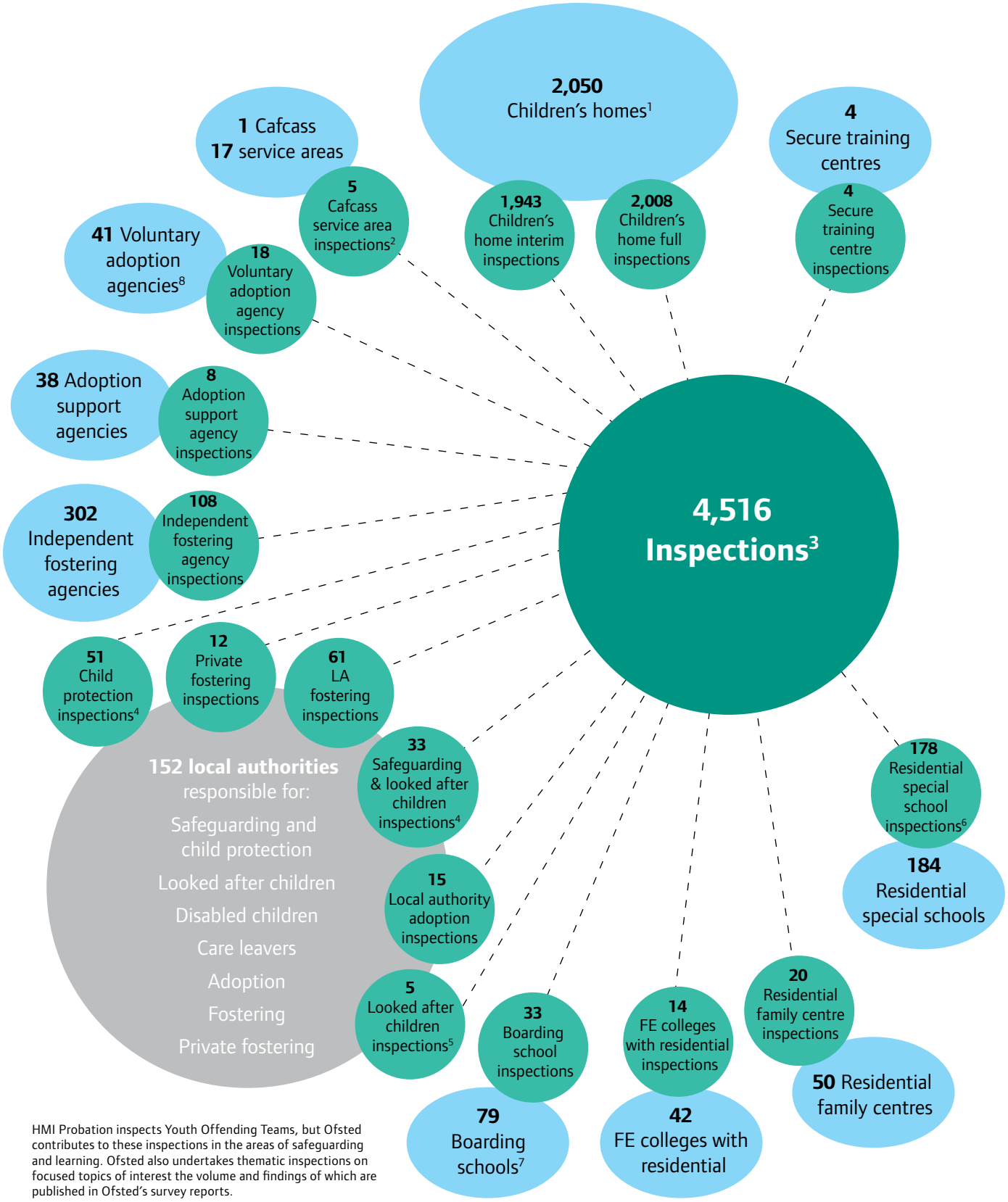
2012–13

Social care



HMI Probation inspects Youth Offending Teams, but Ofsted contributes to these inspections in the areas of safeguarding and learning. Ofsted also undertakes thematic inspections on focused topics of interest the volume and findings of which are published in Ofsted's survey reports.

FIGURE 1

1. Children's homes receive a full and an interim inspection each inspection year (1 April to 31 March). The exceptions to this are for newly registered homes and homes not providing care for children for long periods of time.
2. These Cafcass service area inspections relate to 23 local authorities.
3. These data relate to inspections that took place between 1 April 2012 and 31 March 2013 for all providers, with the exception of safeguarding and looked after children inspections and child protection inspections. For these types of inspections the data relate to inspections that took place between 1 April 2012 and 31 July 2013. These data only include published reports and so do not include pilot inspections undertaken in the period.
4. These data relate to inspections that took place between 1 April 2012 and 31 July 2013.
5. These data relate to inspections that took place between 1 June 2013 and 31 July 2013.
6. Residential special schools receive a welfare inspection once a year. In 2012-13, with DfE's agreement, six schools rated outstanding at their last inspection had their inspections deferred to early in the 2013-14 inspection year. This was due to delays in changes to the regulatory framework.
7. Ofsted only conducts welfare inspections of boarding schools that do not form part of the Independent Schools Council.
8. There are three branches of voluntary adoption agencies in Wales that are inspected by Ofsted because their head offices are in England. These are not included in this publication.

Source: Ofsted

Contents

Data View: Inspection findings can also be viewed at www.dataview.ofsted.gov.uk. Data View enables users to compare the performance of providers over time from Ofsted inspections across England by region, local authority and constituency area.

The report includes direct quotes from children and young people where they have summed up what was being said as part of a survey. These quotes are verbatim.

Foreword

We are alert to the reality that too many children, often in our most marginalised communities, live in families with multiple, complex and enduring difficulties. We are seeing evidence that children are safer today than in the past, but too many children are still at risk of harm. Escalating the pace of change for our most vulnerable families depends on a strong and effective social care system complemented by the right support from universal, targeted and specialist services.

Ofsted's contribution must be to continue to raise expectations in respect of the lives of children, as well as the performance of services. We will continue to hold local authorities and social care providers to account and we will be rigorous in doing so.

But we recognise that local authorities and the partners who work alongside them have a complex task. Children's social care services remain under significant pressure. The public rightly demands strong action in response to the maltreatment of children and young people. Local authorities must balance the need to respond to public concern while preserving the stable environment that is needed to improve services.

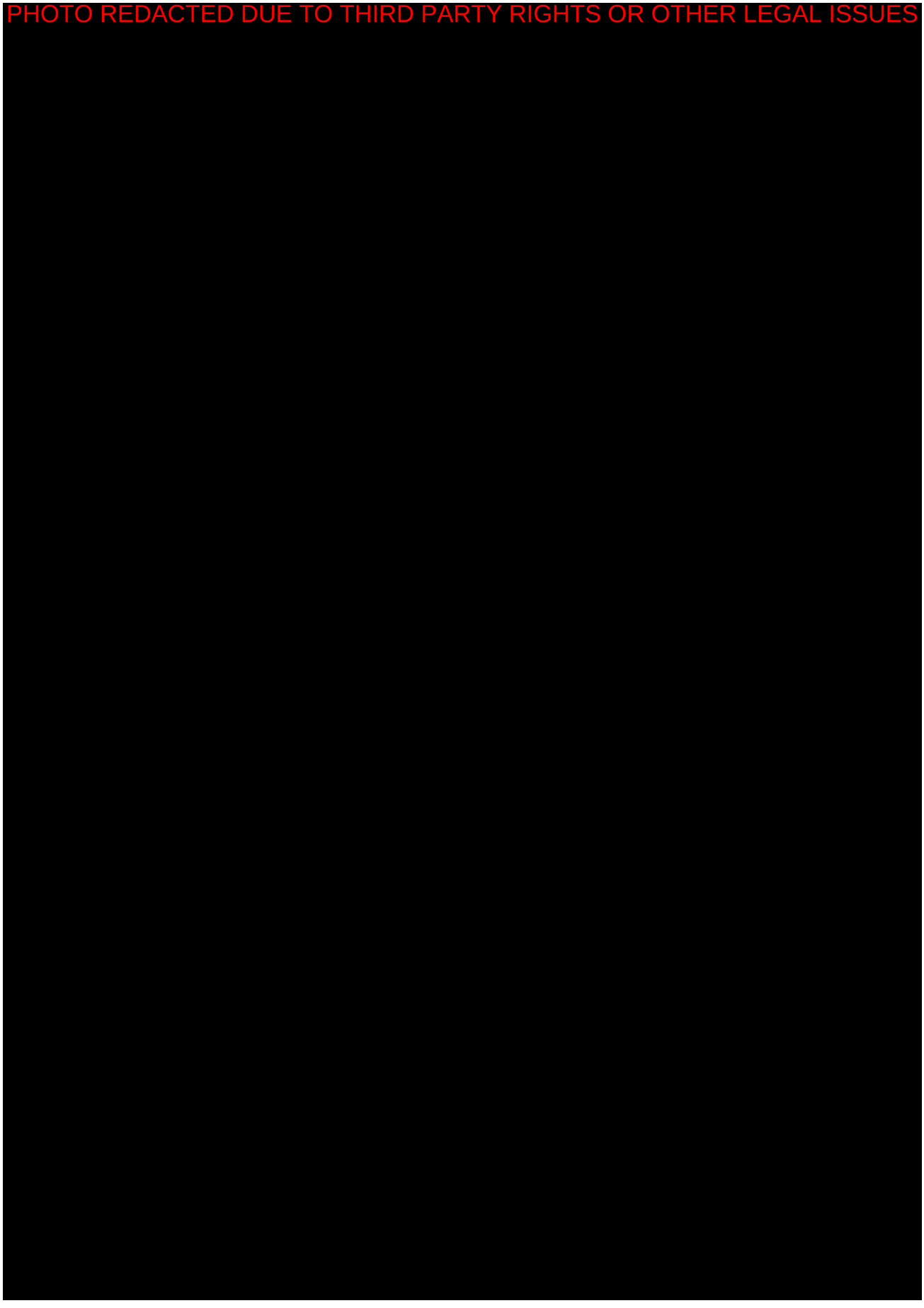
Children's social care is characterised by complexity, risk and the responsibility for making decisions that can change the course of a child's life. While some local areas are balancing these pressures adeptly, other areas continue to struggle to manage rising workloads and unstable staffing levels and leadership. Ofsted's scrutiny of local authorities that are finding change difficult can add to that pressure, but we make no excuses for continuing to ask hard questions.

The picture of performance that we present here shows that there is clearly an ongoing need for improvement. No one expects that accurate predictions can be made in every case about the circumstances and events that put families under greater stress, sometimes resulting in the serious injury or death of a child. But some services are increasingly expert at reducing risk, helping families to look after their children and enabling children at risk in their area to good progress confidently.

It can be done, and therefore it must be done, in all areas, equally well. We will do more to support authorities to make the improvements that children deserve. Our offer of support to inadequate authorities is designed so that we stay alongside them until there is evidence of good progress. Every inadequate authority will need to submit a plan for improvement.

Ofsted supports the principles driving recent system reforms. We wait to see the impact of these changes. We are changing too, trying to focus harder in our inspections on the experiences and actions that make a difference to children and their families. There is a balance to be struck between looking carefully at professionals and organisations and stepping outside systems to see life from the perspectives of families and children. Inevitably, there will always be more we can do to get this balance right, and we remain committed to improving how we do so in the future. You may judge us on the extent to which we can answer the question which matters most: what difference has this made to the lives of young people?

Debbie Jones,
National Director,
Social Care, Ofsted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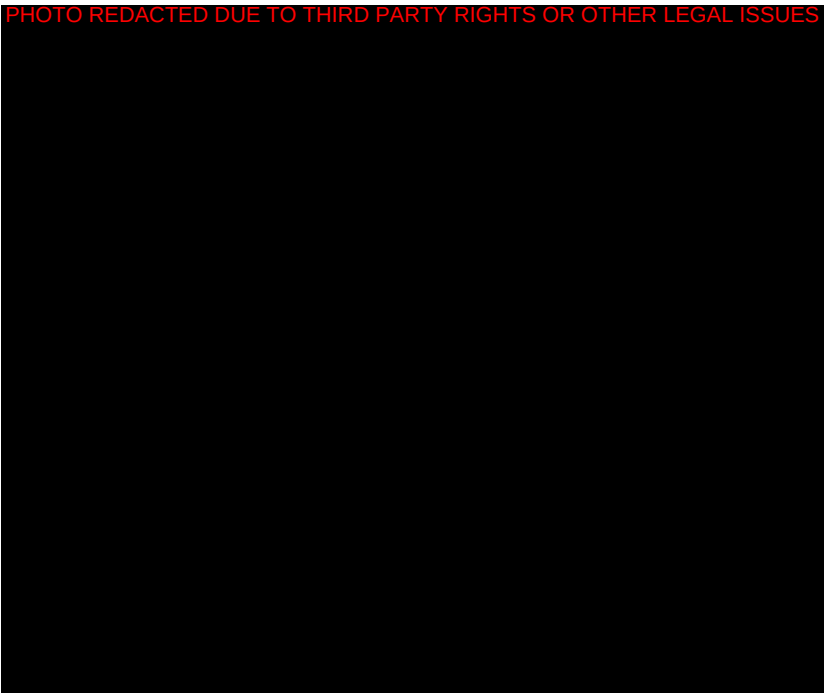
Executive summary

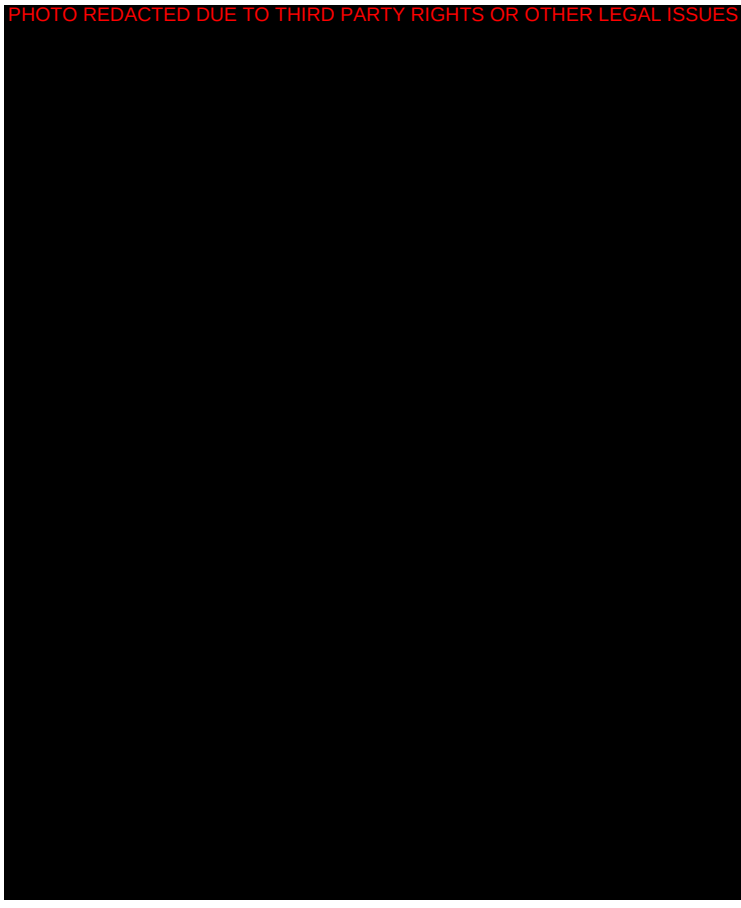
The past decade has seen a series of high profile inquiries and reviews following the deaths or serious injuries of children. This has triggered a major programme of reform, some of which is only now beginning to take shape. There is greater public awareness of abuse and neglect in families and, being at the forefront of this concern, local authorities are managing increasing workloads. This comes at a time when expenditure in the public sector is decreasing. These factors create a pressurised environment that magnifies the impact of weaknesses in some local authority areas.

Although local authorities are the focus of most scrutiny, tackling the root causes of abuse and neglect depends on a much wider group of services to support change for families. Thousands of children live in families where abuse of alcohol and drugs, domestic violence and mental illness are a daily part of life. It is those children who live in families with multiple stresses who are at the greatest risk of harm. Both identifying risks and preventing harm depend on the cooperation of health services, police, schools and the wider community. Areas where local authority child protection services are weak often have weak support from their statutory partners. Every agency with a statutory duty to safeguard and protect children must prioritise that responsibility and ask themselves hard questions about how effectively they are meeting their obligations.



Social care must continue to increase the extent to which the lived experience of each individual child is understood and shapes those services that affect them. The overall trend over many years suggests that abuse and neglect overall may be declining and outcomes for looked after children are improving. However, the proportion of children affected by abuse and neglect remains too high and new information, such as the exposure of the extent of child sexual exploitation, continues to emerge about the harm being done to children and young people in our communities.

We also see from our inspection evidence that overall trends of improvement mask failings for individual children. Being ambitious for individual children will require a much more widespread practice of identifying what progress looks like for each child. We are particularly concerned that fragmentation in the social care system can make it difficult for local authorities to understand whether services are meeting the needs of individual children, and this will be a focus for our inspection in future.



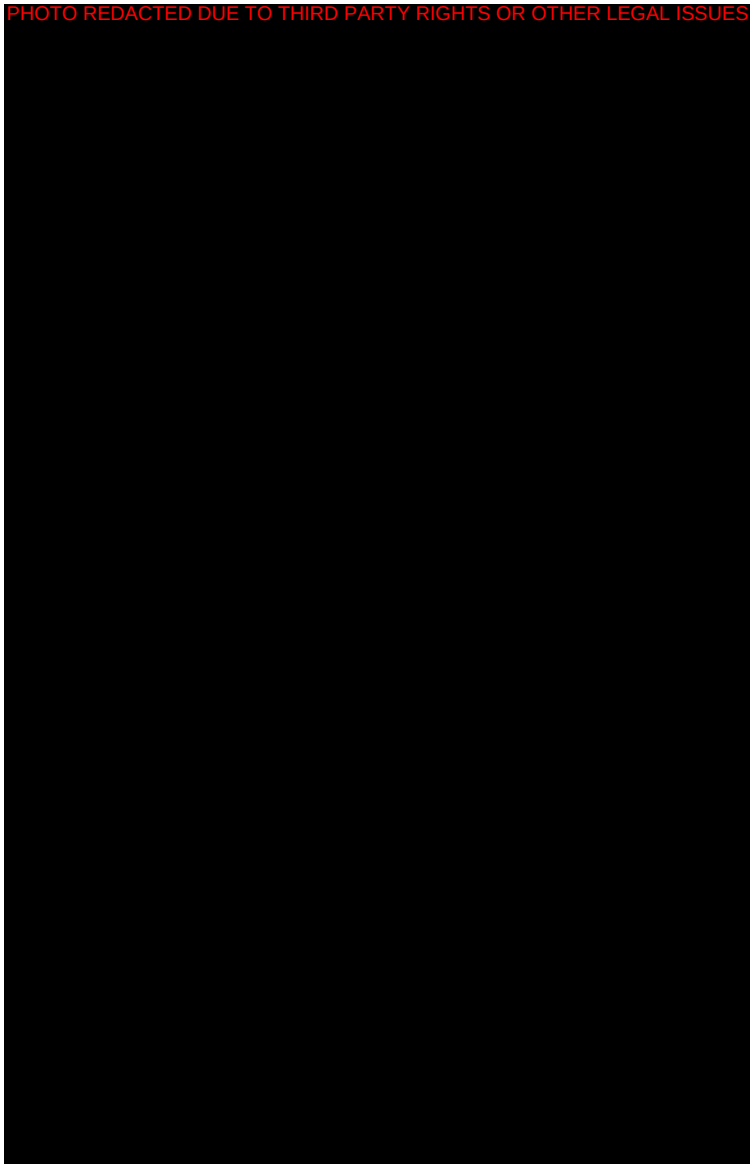
While trends in child deaths and outcomes for looked after children suggest that some progress is being made, there is still clearly a need for improvement in the performance of local authorities. At the end of the first full cycle of local authority inspections, we judged around four in 10 local authorities to be good or better for safeguarding. We also found 17 local authorities to be inadequate. After reinspecting the weakest, focusing on child protection as the area of highest risk, this increased to 20 inadequate local authorities. What makes this picture complex is the extent to which the cohort of local authorities has changed position between the two inspections. The group of authorities currently judged inadequate is different to the group with an inadequate judgement last July. Additionally, four local authorities have improved convincingly and are now judged good, some with a trajectory that may improve further.

Where local authorities are failing, many are operating in a context of considerable turmoil. A commitment to change is in evidence throughout, but a lack of stable leadership and a lack of understanding about what constitutes good practice, often coupled with an unrealistic view of the quality of practice at the front line, mean that change programmes in these authorities are not delivering improvement. In the weakest places, the most basic acceptable practice is not in evidence. There are weaknesses in supervision, management oversight, purposeful work with families and decisive action when children are at risk of being harmed. Conversely, where change programmes have worked, local authorities have focused intently on front-line practice and management: their senior leaders have made sure that expectations were clear; and they scrutinised the impact of practice on children and families.

In our inspections of regulated services such as adoption, fostering and children's homes, a high proportion were found to be good or better in the last complete cycle. Although this is a fair picture of the extent to which these services have met minimum standards set by the government, we are not satisfied that the standards are ambitious enough for children. Nor do they demand enough from owners and managers of these services. As we implement changes to our inspection frameworks for these services and collaborate with government on standards, it is likely to be the case that a focus on how services are supporting children and young people to succeed may well result in less generous judgements.

We continue to be concerned about the impact that inconsistent management has on regulated services. Our inspection of children's homes clearly demonstrates that those children's homes that have consistently underperformed are least likely to have continuity of management. The negative impact of absent or inconsistent management applies equally in the secure estate and in adoption and fostering. Additionally, the management of behaviour in residential settings remains an ongoing concern. Weaknesses in practice relating to restraint and sanctions, but also in encouraging positive behaviour through effective rewards and providing specialist help, remain a problematic aspect of residential care.

We will be taking action to re-focus both our inspection frameworks and the support we will be offering through our regional structure. Our priority throughout will be to set an ambitious standard for the lives of our most vulnerable children and young people. Only good is good enough in their care and protection, and our use of the 'requires improvement' judgement will recognise this. We will be testing ourselves and those we inspect against our vision of a stronger social care system: fewer gaps, more evidence of collective responsibility and the long-term success of each child, young person and family at the forefront of every action taken.



An enduring spotlight – higher expectations, closer scrutiny

1. Social care remains a system under pressure. Over the past decade, there has been a series of high-profile cases concerning the death or injury of children at the hands of their parents and carers. This has resulted in a series of public inquiries, national progress reviews, select committee inquiries, major government change programmes and significant reforms to the frameworks for inspection and regulation.

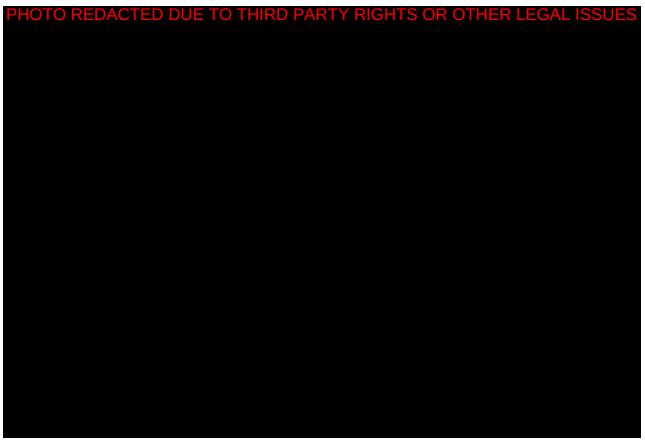
2. The consequence of this scrutiny has been a large-scale programme of reform focused on: tackling longstanding issues in recruitment and retention; the need to hear and focus on the experiences of children; the skills and status of the social work profession; and re-focusing work away from bureaucracy and towards strengthening professional judgement. That programme of reform has not been as swift or decisive as we would have hoped. The 'Working Together' guidance has only recently been revised by the government; the establishment of the College of Social Work and the appointment of a Chief Social Worker are also recent developments. Whether these reforms will have the anticipated impact should shortly become clearer.

3. A further consequence of high profile cases may be a greater awareness of the prevalence of abuse and neglect, as suggested by rises in the levels of demand. Recently, public debate has been rekindled by new cases that raise questions about the effectiveness of our protective services: initially by the abuses of young girls by at least 31 men, now convicted of these crimes, that have been brought to light in three English towns; and, more recently, by new cases of child deaths caused by abuse and neglect.

4. Local authorities have come under close scrutiny. In some cases, their performance has rightly and necessarily been called into question. In areas with effective leadership, they have managed well even when constant scrutiny has created instability. But in areas without effective leadership, instability has impeded progress.

5. The total volume of activity by local authorities has increased since 2008. The biggest increase in activity has been in core assessments – the most in-depth and complex assessments – which have more than doubled. This increase in volume is not replicated in every local authority equally. Some individual local authorities have seen activity drop and some local authorities have seen a dramatic increase in their volume of work.[1] There are no simple means to establish whether increases or decreases represent an improving picture, due to the complexity of factors driving changes in volume. What is unarguable is that activity overall continues to climb. The growth in the number of looked after children alone represents an estimated additional £173 million pounds a year in added costs to the system.[2]

6. Data from the Institute for Fiscal Studies on the central government funding allocation to local government show a 26.6% reduction in local authority budgets in the five years from 2010.[3] Meanwhile, it has been reported that, although some areas have invested in more front-line social work posts, the number of children's social care posts across the UK has fallen by 4%.[4] Inspection evidence from local authorities and children's homes shows the disruptive impact of using short-term staffing solutions, particularly when the annual staff turnover rate of care staff can be as high as 16%.[5]



1. Characteristics of children in need in England, 2011-12, Department for Education, 2012; www.gov.uk/government/uploads/system/uploads/attachment_data/file/219174/sfr27-2012v4.pdf. **2.** *Safeguarding pressures phase 3*, ADCS, October 2012; www.adcs.org.uk/news/safeguarding-pressures.html. **3.** *The squeeze continues*, Institute for Fiscal Studies, June 2013; www.ifs.org.uk/publications/6740. **4.** CommunityCare website, www.communitycare.co.uk/Number-of-social-work-posts-falls-6-in-a-year/. **5.** *The local authority children's social care services workforce*, England, 31 December 2012, Department for Education 2013; www.gov.uk/government/publications/the-local-authority-childrens-social-care-services-workforce-england-31-december-2012.

7. These external factors create a pressurised environment for children's social care services. They are not insurmountable pressures, but can make weak services more fragile and counteract attempts to drive improvement where measures are insufficiently robust or comprehensive.

Social care volumes (2008–12)

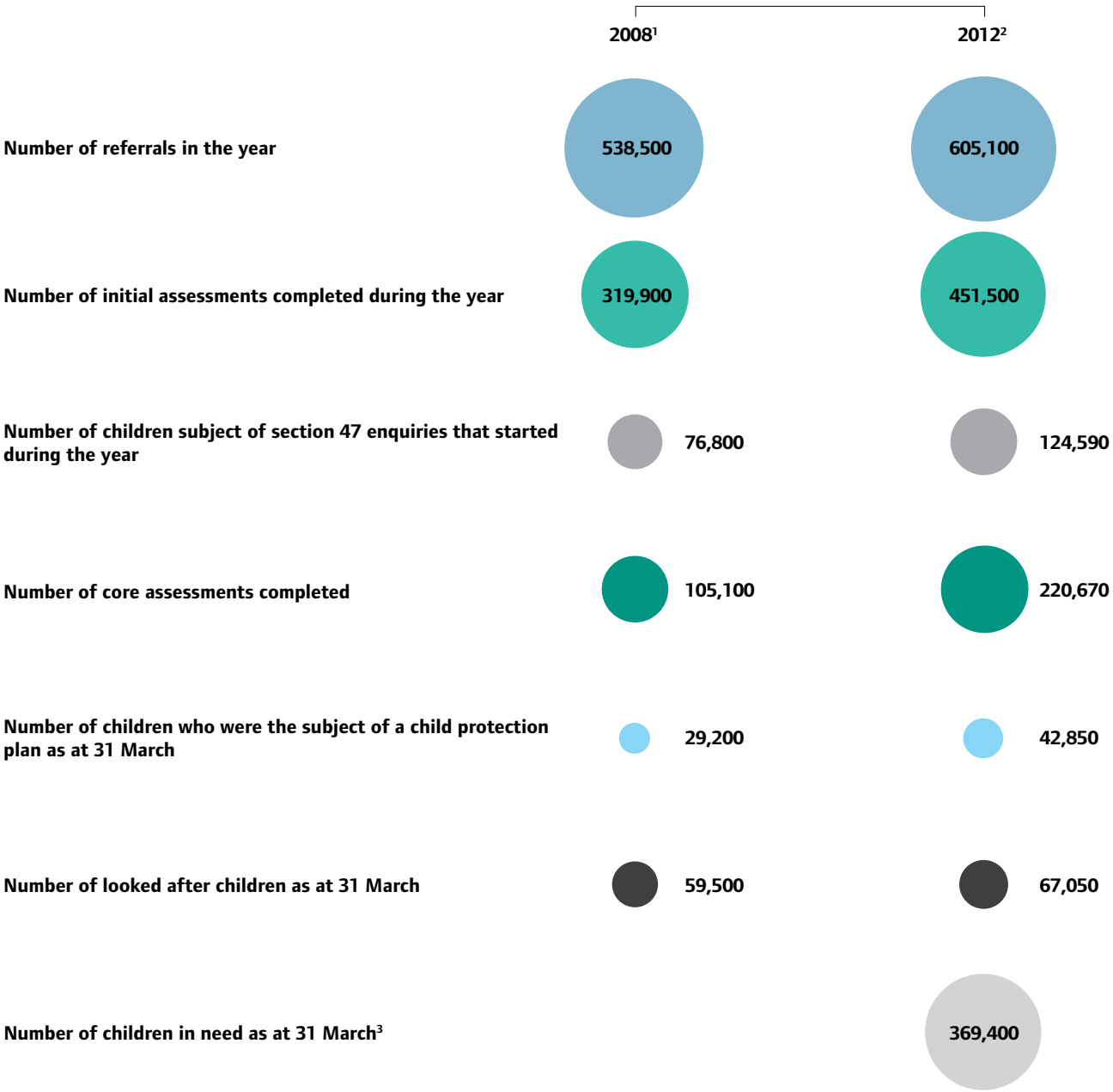


FIGURE 2

1. DCSF: Referrals, Assessments and Children and Young People who are the subject of a Child Protection Plan, England – year ending 31 Mar 2008 (http://webarchive.nationalarchives.gov.uk/20130401151655/http://www.education.gov.uk/researchandstatistics/statistics/statistics-by-topic/childrenandfamilies/a00195890/referrals-assessments-and-children-who-are-the-sub); DCSF: Children looked after in England (including adoption and care leavers) year ending 31 March 2008 (http://webarchive.nationalarchives.gov.uk/20130401151655/http://www.education.gov.uk/researchandstatistics/statistics/allstatistics/a00195856/children-looked-after).
2. Characteristics of children in need in England: year ending March 2012 (https://www.gov.uk/government/publications/characteristics-of-children-in-need-in-england-year-ending-march-2012); Children looked after by local authorities in England, including adoption (www.gov.uk/government/publications/children-looked-after-by-local-authorities-in-england-including-adoption).
3. No data collected in 2008.

Source: Department for Education

Social care alone is not enough

8. As the inspectorate for children's social care, we have the responsibility to assess the quality of services and to promote their improvement. Understanding the causes of failure and success depends on understanding the social care system and its strengths and weaknesses. But it also depends on understanding the wider context; not just what happens, but why it happens.

9. We have a social care system because society has a responsibility for securing the safety of our children. It is not only their present wellbeing we must secure, but their future as parents and carers. The impact of damage from harm in childhood can be passed on to the next generation if young people who have been abused or neglected in childhood grow up to become abusive or neglectful parents. Some children live with serious and complex difficulties in their families, and we need to examine what we can and should do earlier in their lives.

10. It is estimated that 2.6 million children are living with parents who drink hazardously; 705,000 of those are dependent on alcohol. More than 100 children (including children as young as five) contact Childline every week with worries about their parent's drinking or drug use. In a study by four London boroughs, almost two thirds of cases of children subject to care proceedings involved parents misusing alcohol or drugs.[6] In a study of youth offending cases in 2010, 78% of those young people misusing alcohol had a history of parental alcohol or domestic abuse in their family.[7]

11. The National Treatment Agency for Substance Misuse in 2011–12 treated around 100,000 adults who were either parents or lived with children.[8] Estimates suggest that there are 130,000 children whose family life is damaged by past or present domestic violence and an estimated 17,000 children are living with parents with a severe and enduring mental illness.[9,10]

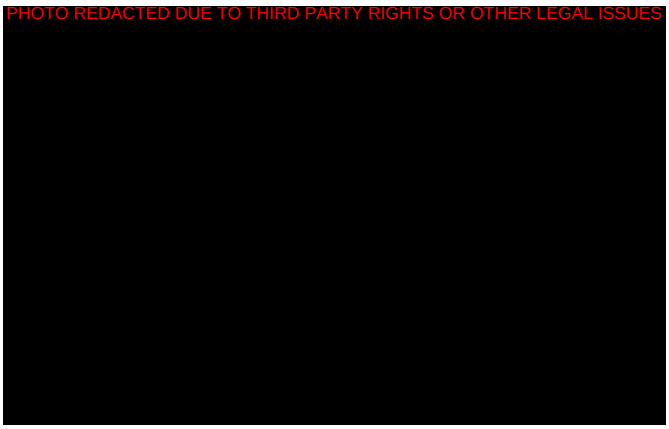
> Ofsted's thematic inspection report *What about the children?* looked at joint working between children's social care and services provided for adults with drug, alcohol, or mental health problems.[11] In the case of parent or carer mental ill health, the impact on the child was not comprehensively considered in most assessments. When parents or carers had drug or alcohol problems, children's and adult's services were better at collaborating to develop a good understanding of the impact on the child. Most of the long-term cases were complex and challenging. Parents' and carers' difficulties were not easily, and sometimes never, resolved and progress was often not sustained. Improvement was often measured in terms of the parents' activity and behaviour rather than monitoring the long-term impact on children of living within these households.

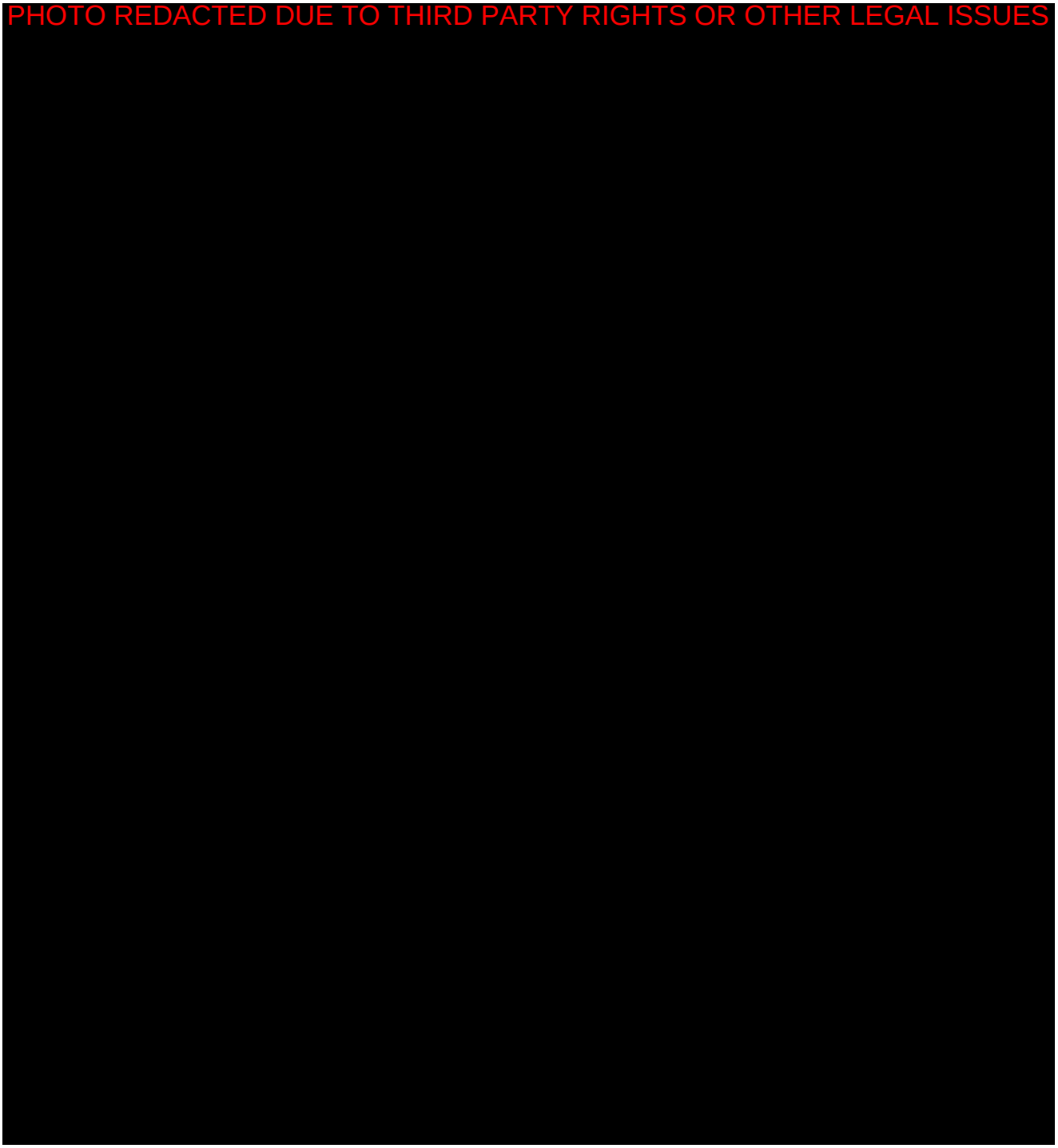
12. Evidence from serious case reviews shows that it is the aggregation of parental problems that causes the most harm to children. Almost nine out of 10 serious cases between 2009 and 2011 involved at least one of parental mental ill health, domestic violence or misuse of alcohol or drugs. However, it is the combination of these factors that has been described as 'toxic' and many cases involved all three.[12]

13. It is evident that the harm that children can suffer from living in families with complex problems cannot be prevented by the social care system alone. There must also be a coordinated response from a range of services, including health, police, schools, national policy makers and communities themselves. Together, they must create an environment that supports and nurtures families and challenges and intervenes to prevent unacceptable behaviour.

6. *Swept under the carpet: children affected by parental alcohol misuse*, Alcohol Concern and The Children's Society, 2010, www.alcoholconcern.org.uk/publications/policy-reports/under-the-carpet. **7.** *Message in a bottle, a joint inspection of youth alcohol misuse and offending*, Care Quality Commission, 2010; www.cqc.org.uk/content/message-bottle-joint-inspection-youth-alcohol-misuse-and-offending. **8.** *Parents with drug problems: how treatment helps families*, The National Treatment Agency for Substance Misuse, 2012; www.lifeline.org.uk/articles/parents-with-drug-problems-how-treatment-helps-families/. **9.** *A place of greater safety*, Co-ordinated Action Against Domestic Abuse (CAADA), 2013; http://www.caada.org.uk/policy/research-and-evaluation.html. **10.** *Parents with mental health problems*, Mental Health Foundation, 2013; http://www.mentalhealth.org.uk/help-information/mental-health-a-z/P/parents/. **11.** *What about the children? Joint working between adult and children's services when parents or carers have mental ill health and/or drug and alcohol problems* (130066), Ofsted; www.ofsted.gov.uk/resources/what-about-children-joint-working-between-adult-and-childrens-services-when-parents-or-carers-have-m. **12.** *New learning from serious case reviews: a two-year report for 2009 to 2011*, Department for Education, 2013; www.gov.uk/government/publications/new-learning-from-serious-case-reviews-a-2-year-report-for-2009-to-2011.

14. Our inspection evidence demonstrates that good local authorities and their partners understand their area and the needs of families who live there, and commission their services accordingly. The evidence also shows that the weakest child protection services often struggle to secure effective collaboration with other local services. Local authorities must be good partners who create an environment where collaboration thrives. Equally, they must be able to rely on the highest quality response from health services, police, courts and schools. There can be no weak link in the chain.





Inspection focused on the experiences of children and families – the bar is raised

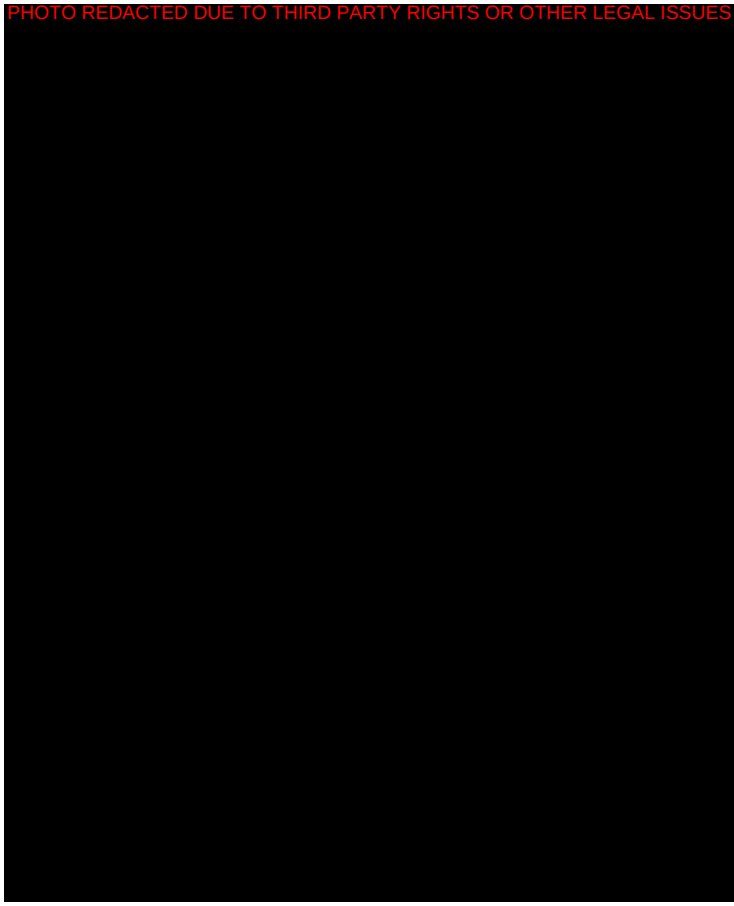
15. While successive reviews of individual failures in the social care system have emphasised the need for system change, they have also made the case that a social care system that looks only at organisations, management and activity is a social care system that will fail children. Social care only succeeds where it sees and hears children, understands their potential and the stresses that they face, and listens to them when they call for help, no matter how difficult to interpret that call may be.

The prevalence of abuse and neglect

16. The first question we naturally ask is how many children in our communities are suffering abuse and neglect. Do we live in a time or a country where they are particularly prevalent? It is extremely difficult to judge the extent of abuse and neglect. With any criminal or anti-social behaviour, merely assessing the volume of activity undertaken by protective agencies may only indicate changes in how those agencies are delivering services rather than the threat such behaviour poses at any given time.

17. There are no robust and easily comparable measures of the extent of abuse and neglect. The measure that allows some comparison over time is child homicide. This is because there is a strict definition as to what is classified as homicide that remains relatively constant. This figure will not include all children who die as a result of abuse or neglect, for example where a parent who is under the influence of alcohol or drugs accidentally rolls on top of a baby while sleeping, or where children commit suicide in households where there is abuse or neglect.

18. Using child homicide as a measure, there is a very slight decline in numbers and rates between 1977 and 2012.[13,14] The OECD has compared the deaths by intentional injury for the period 2003–08 for developed countries and, on this measure, the UK has a moderately low level of deaths.[15,16]



13. *Focus on: violent crime and sexual offences*, Office for National Statistics, 2011-12; www.ons.gov.uk/ons/rel/crime-stats/crime-statistics/focus-on-violent-crime/stb-focus-on--violent-crime-and-sexual-offences-2011-12.html. **14.** There were major changes in crime recording practice in both 1998 and 2002. These changes are very unlikely to have had an impact on the recording of homicide. The time period for recording homicides changed in 1998 from calendar to financial year. **15.** Using World Health Organization data on child mortality and out of 34 countries (33 OECD countries plus Brazil), the UK had the 5th lowest rate, although the UK's rate did not differ markedly from 24 of these countries which all had a rate below 1.0 in 100,000. **16.** *Doing better for families*, chapter 7, child maltreatment, OECD, 2011; www.oecd.org/els/soc/doingbetterforfamilies.htm.

Homicide victims aged under 18 in England and Wales, 1977 to 2012

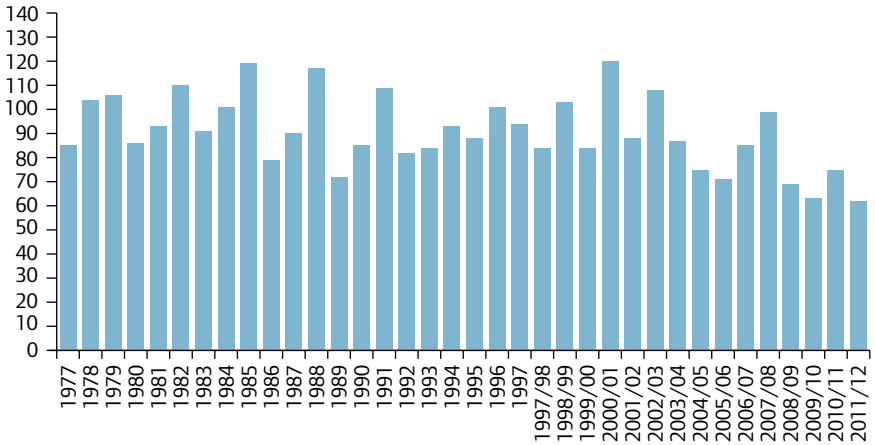


FIGURE 3

Table 2.03 in *Focus on violent crime and sexual offences, 2011/12*, at www.ons.gov.uk/ons/rel/crime-stats/crime-statistics/focus-on-violent-crime/stb-focus-on--violent-crime-and-sexual-offences-2011-12.html.

Source: Home Office Homicide Index

Homicide victims aged under 18 in England and Wales, 1977 to 2012, rate per 10,000 population under 18

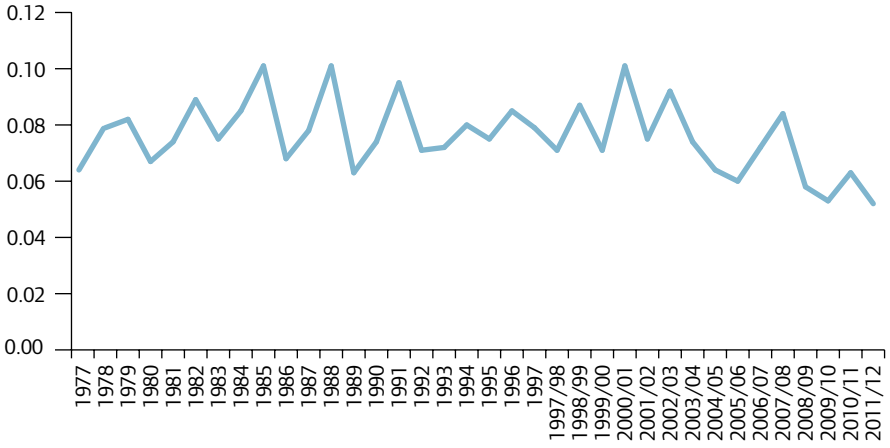


FIGURE 4

Table 2.03 in *Focus on violent crime and sexual offences, 2011/12*, at www.ons.gov.uk/ons/rel/crime-stats/crime-statistics/focus-on-violent-crime/stb-focus-on--violent-crime-and-sexual-offences-2011-12.html.

Source: Home Office Homicide Index

19. For every child who dies, we know that there are many more who suffer injury. The psychological and emotional scarring can affect them throughout their lives. The NSPCC conducted research with children, documenting their experience of severe maltreatment using definitions conventionally used in child protection practice. On the basis of this research, they estimated that 5.9% of children under 11 and 18.6% of 11–17-year-olds have experienced some form of severe maltreatment in their lives, either at home, at school or in the community; an estimated 2.5% and 6.0%, respectively, have experienced severe maltreatment by a parent or carer in the past year.[17]

> In our thematic inspection on the impact of neglect, due to be published later in the autumn, nearly half of assessments seen did not take sufficient account of the family history, and half did not sufficiently convey the impact of neglect on the child. The practice of engaging parents in child in need and child protection work was found to be a significant challenge for professionals. There were examples of drift and delay in almost a third of cases. This meant that children's social care did not always take appropriate action at the right time to meet the needs of the children. In a fifth of the sample, there had been missed opportunities for care proceedings to be initiated, resulting in children being left in situations of neglect for too long.

The success of looked after children

20. When we seek to judge whether progress is being made in keeping children safe, an indication is whether outcomes for looked after children are improving. Children suffering harm must be identified early; decisive intervention must come at the right time to prevent further harm; and the plan for the child must be a good one based on a thorough assessment of need. Unless this happens, children who are looked after are not be in a position to progress and compare favourably with their peers who have had a less challenging start in life.

> **At first I didn't trust anyone, but now see that all they wanted was the best for me.**
> *(Child's view from children's homes survey)*

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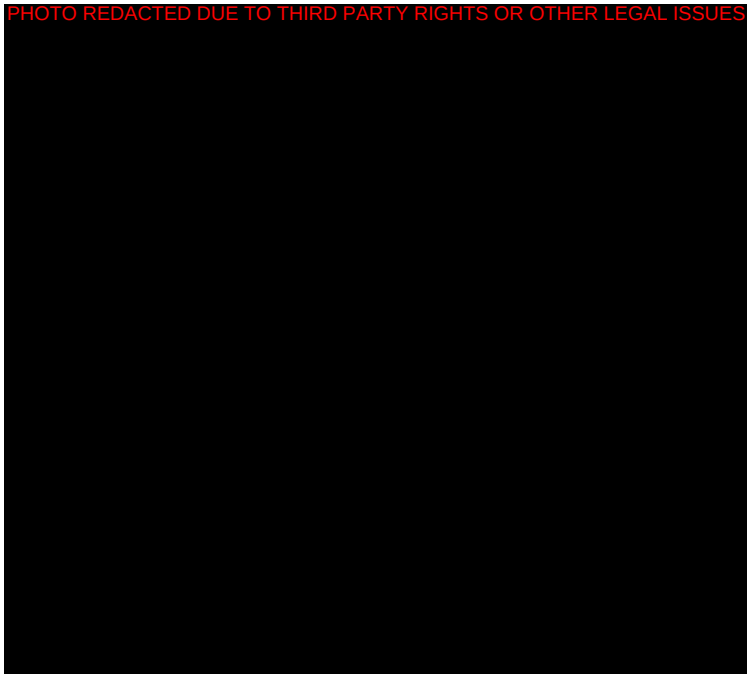


> **Because I am not left alone. They never let anything bad happen to me. I feel protected. They do the right things for me. They make me feel happy. If I am sad they make me feel better.**
> *(Child's view from the fostering survey)*

17. *Child abuse and neglect in the UK today*, NSPCC, 2010; www.nspcc.org.uk/Inform/resourcesforprofessionals/sexualabuse/statistics_wda87833.html.

21. We are seeing some improvement in outcomes for looked after children, but the starting place was an unacceptably low base. For the youngest children where intervention happened earliest in their lives, there has been steady year-on-year improvement in outcomes. For older children where care services may not have intervened quickly enough to prevent significant damage, improvement is patchy. For children leaving care, employment, housing and education outcomes are declining, but this is in a context where all young people are struggling in a challenging economic climate.[18]

22. At age 11, half of looked after children do not reach the expected level in English and mathematics. This gap increases to five out of six at age 16. Seven out of 10 looked after children have special educational needs. In 2011–12, one in six looked after children were not in education, employment or training at the end of Year 11 of school, one in 25 were identified as having a substance misuse problem and as many as one in 14 were subject to a conviction, final warning or reprimand.[19] It is estimated that more than seven out of 10 looked after children have behavioural or emotional difficulties.[20] Looked after children are given the highest priority in the allocation of school places, and yet more than 9,000 are being taught in schools that are less than good, including almost 1,500 in inadequate schools.[21]

23. There is no duty for local authorities, or any other organisation, to collect data on the destinations of children who have been looked after once they reach the age of 19. This means there is little accountability for what happens to these children later in life and little reliable information on how their adult lives compare with others of the same age, although the best local authorities will do more to track progress. However, some facts are known about the adverse effect of harm in childhood. For example, while 2% of the general adult population were, at some point, looked after by a local authority,[22] around a quarter of the prison population have been in care during their childhood.[23]

24. One aspect of the experience of looked after children that has only recently been brought to light is the prevalence of sexual exploitation among our most vulnerable children. The Children's Commissioner has published estimates that in one year at least 16,500 children were at risk of sexual exploitation and 2,409 children were confirmed as victims of sexual exploitation in gangs and groups.[24] A disproportionate number of these young people were being looked after by local authorities at the time of the abuse. The slow pace adopted by some local authorities in acknowledging this trend and acting on it is of pressing concern.

> **I do worry sometimes about how it will turnout in the future if I say my feelings.**
> *(Child's view from fostering survey)*

> **Sometimes I don't feel safe because of my bad start in life.**
> *(Child's view from adoption survey)*

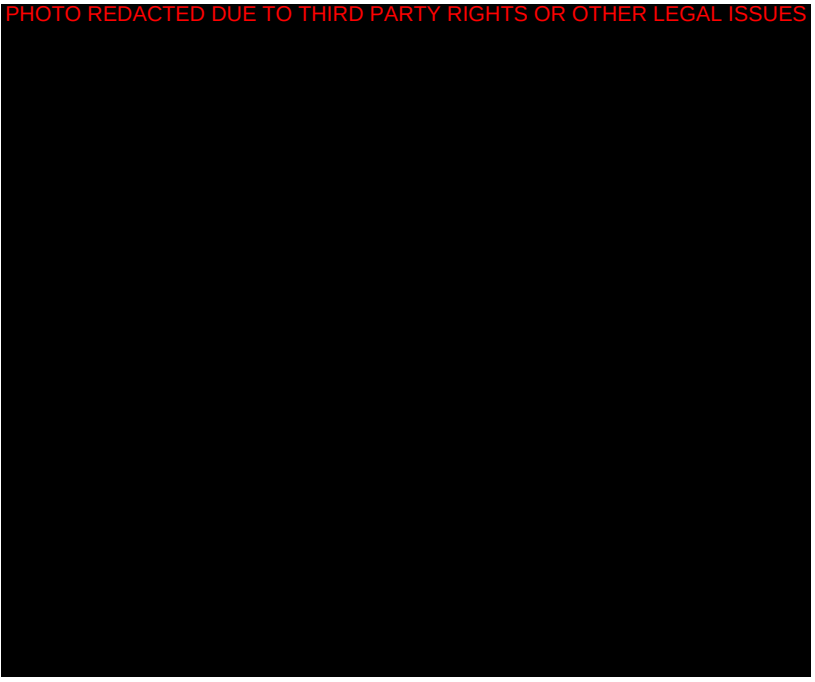
Evidence from children's home inspections shows that some homes are responding well to the greater focus on progress in education and are more structured in their approach. There are still too few who have any real sense of how well they prepare young people for a successful transition into adult life.

In our thematic report on missing children, due to be published later in the autumn, inspectors found that professionals frequently focused on the risk-taking behaviour of the young people, rather than trying to understand what was underpinning the behaviour. Often, return interviews were not held and where they were there was little sense of trying to understand anything other than the individual incidents, rather than attempting to piece together an overall picture of what was going on for the individual young person at that time.

18. *Outcomes for children looked after by local authorities in England:* 31 March 2012, Department for Education, 2012; www.gov.uk/government/publications/outcomes-for-children-looked-after-by-local-authorities-in-england-31-march-2012; **19.** *Outcomes for children looked after by local authorities in England*: 31 March 2012, Department for Education, 2012 (www.gov.uk/government/publications/outcomes-for-childrenlooked-after-by-local-authorities-in-england-31-march-2012). The rate of conviction etc. compares with a rate for all children in England and Wales of one in 50 children, although this rate also includes cautions (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/218552/yjb-stats-2011-12.pdf) **20.** www.youngminds.org.uk/training_services/policy/mental_health_statistics. **21.** January 2012 census, RAISEonline and Ofsted school inspection data, June 2013. **22.** *Reducing re-offending by ex-prisoners*, Social Exclusion Unit, 2002; www.thelearningjourney.co.uk/file.2007-10-01.1714894439/file_view. **23.** *Prisoners' childhood and family backgrounds*, Ministry of Justice, 2012. **24.** *Child Sexual Exploitation and the response to localised grooming*, Home Affairs Select Committee, 2013.

> **There were two brothers placed with current foster carers. One brother absconded and refused to remain with the carer. On leaving he informed us that the family and he and his brother, eat meals separately.**
> *(Social worker's view from fostering survey)*

25. We should be optimistic about the progress that has been seen over recent years. It is also necessary to be both realistic about progress for looked after children and increasingly ambitious. Where a child has already suffered damage before services have intervened, what represents progress will be very personal to them. Expecting strong performance at GCSE level may be futile when, for a child who has been out of school completely for several months, simply attending classes regularly would be welcome progress. But taken too far, this becomes poverty of ambition. Every time a child stays in a damaging situation too long and suffers as a result, an opportunity has been missed to prevent that damage by identifying them and intervening more quickly.



Ofsted's report on the impact of virtual schools[25] found that the better authorities had robust data systems that enabled the virtual schools to monitor and track the progress of children, individually as well as collectively. This enabled the headteacher of the virtual school to promptly address performance issues with schools, professionals and carers. It also facilitated up-to-date performance reporting to senior managers and elected members in councils. Systems that allowed early identification of concerns made a demonstrable difference to the attendance rates of looked after children and, in some cases, educational outcomes. There was a focus on the overall progress of individual looked after children as they advanced through their education, which provided a more insightful picture than annual comparisons of attainment between different year cohorts with varying abilities, backgrounds and lengths of time in care.

> **The social services do not work as a team but as individuals with their own ideas on how the child's needs are best met. This means they usually get it wrong and the Child suffers and becomes another statistic swallowed up in the system.**
> *(Foster parent's view from fostering survey)*

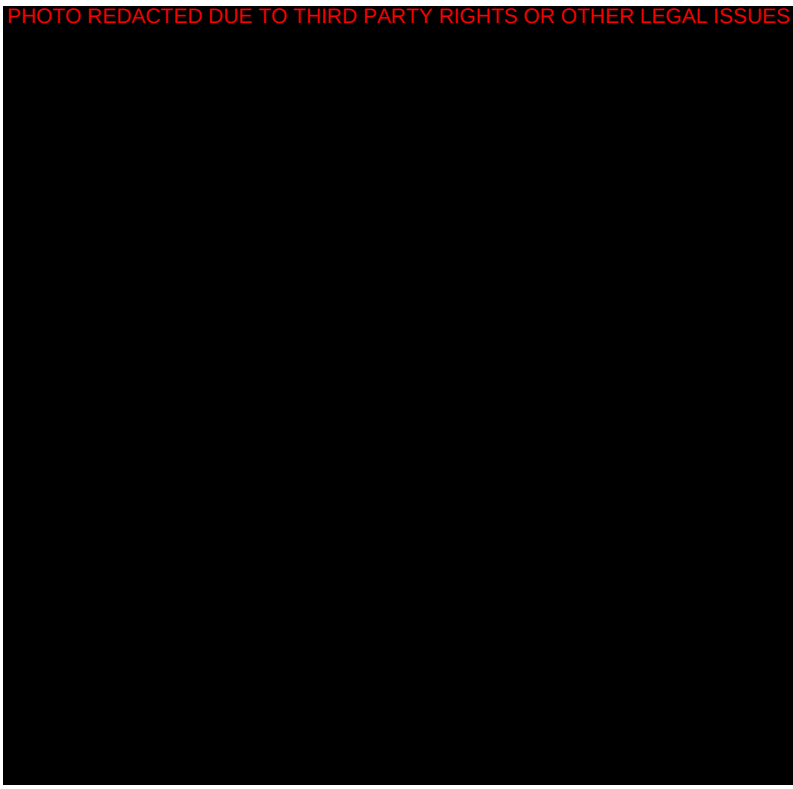
> **I am not going to school at the moment but I am going to go back into education.**
> *(Child's view from children's homes survey)*

25. *The impact of virtual schools on the educational progress of looked after children* (120165), Ofsted, 2012; www.ofsted.gov.uk/resources/impact-of-virtual-schools-educational-progress-of-looked-after-children.

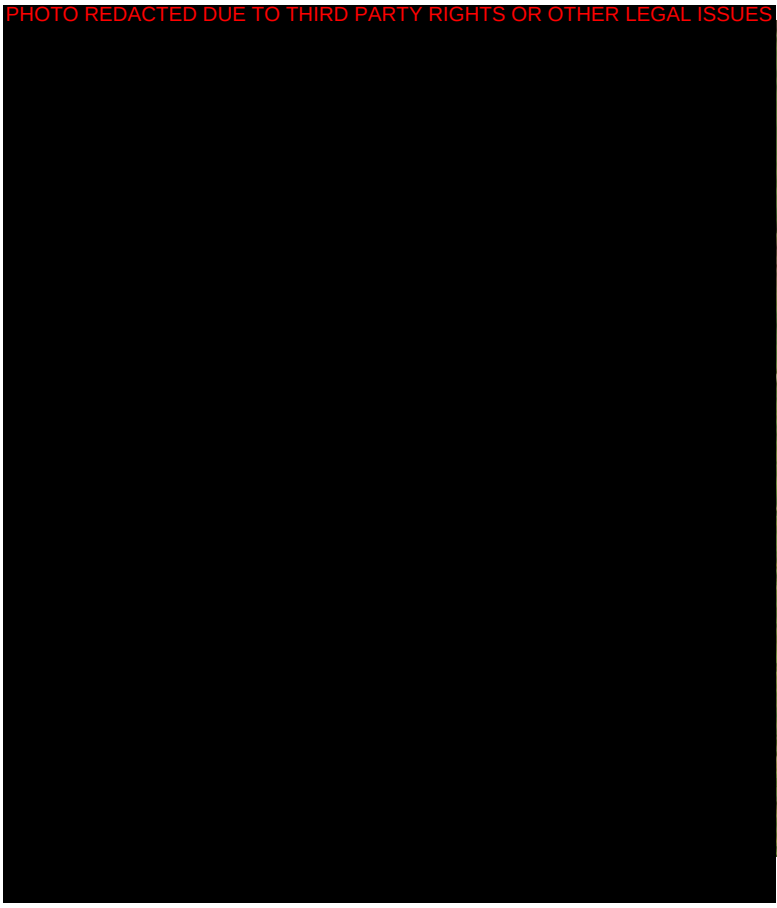
Inspection that focuses on the child's experience

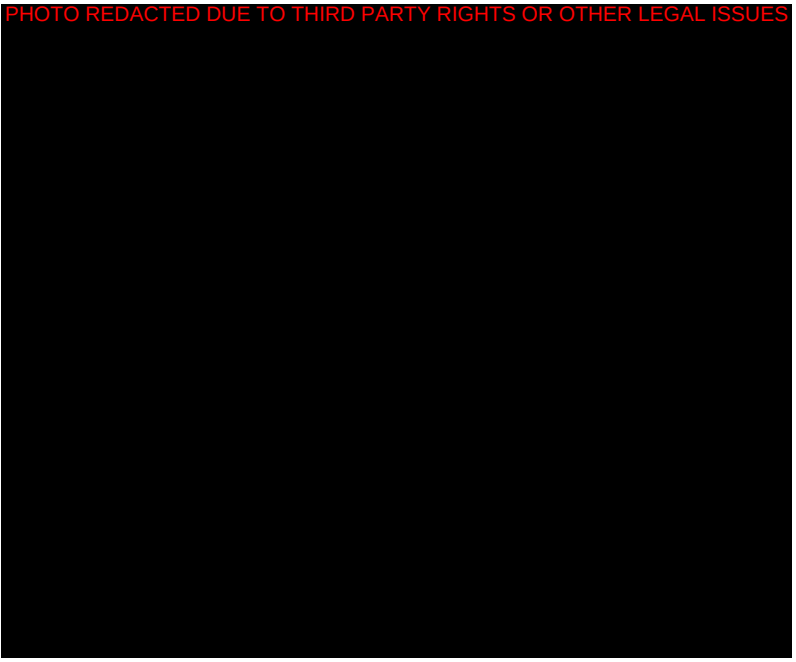
26. It is our contention that the feature of the protection and care system that creates the greatest barrier to a sustained focus on how well children are helped, protected and cared for is fragmentation. It is important to understand a complete picture of a child's life in order for services to be effective in promoting the child's wellbeing. This relates to seeing all the factors at play within families and communities that put a child at risk, as well as seeing the cumulative impact that different services are or are not having on a child's progress.

27. Ofsted will continue to develop local authority inspections that start with children's experiences and describe the quality and impact of help, care and protection. But we will also evaluate the effectiveness of the plan for their care regardless of the place where they live, whether within their own family, a foster home, an adoptive family or a residential children's home. Inspections must connect and evaluate children's journeys over time and they must be ambitious in doing so.



> **I feel like a member of the foster family but sometimes because I know I am going to move to another foster family that is a bit confusing.** *(Child's view from fostering survey)*





The inspection evidence this year

The performance of local authorities

28. In July 2012, we completed a three-year cycle of safeguarding and looked after children inspections and the outcome was that only four out of 10 local authorities were judged good or better for safeguarding.

Overall effectiveness of latest local authority safeguarding or child protection inspection, as at 31 August 2013

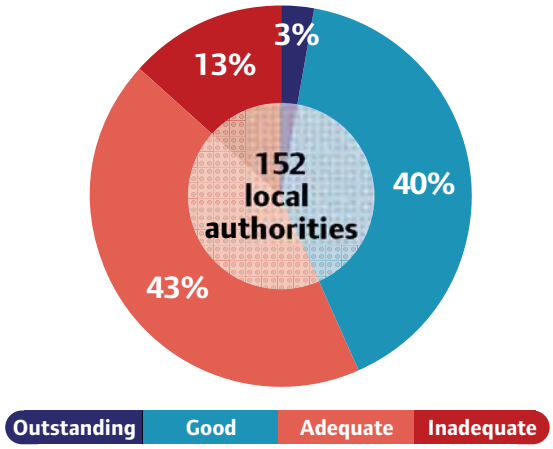


FIGURE 5 This chart shows the most recent overall effectiveness judgements for local authorities.

This reflects outcomes for child protection inspection or, for those authorities who did not receive a child protection inspection, for the safeguarding inspection.

Percentages in the chart are rounded and may not add to 100.

Source: Ofsted

29. Since that time, we have revisited 50 of the weakest places and re-evaluated their arrangements to protect children. In 17 of those local authorities, a judgement of inadequate was given. Three local authorities were previously judged inadequate in their safeguarding inspection and this took place too recently to warrant a further inspection. At the time of publication, there are in total 20 (13%) local authorities with inadequate judgements in their latest inspection of the arrangements to protect children, four of whom have also been recently judged inadequate for the care of looked after children.

Performance in child protection

30. Services to protect children need to improve. Too few are good or better and too many are inadequate. It is not clear, however, whether this is a picture that is getting better or worse. More inspections will be needed to provide a conclusive answer because the current picture is complex.

31. The inspection results of the past 12 months arise from a system where many authorities are finding improvement difficult. Almost half of the inspections did not result in a changed judgement. Adequacy in itself is proving to be a standard where practice can quickly decline. One third (13) of previously adequate authorities in this targeted inspection cycle were newly judged inadequate.

Change in overall effectiveness grade between safeguarding and child protection inspection

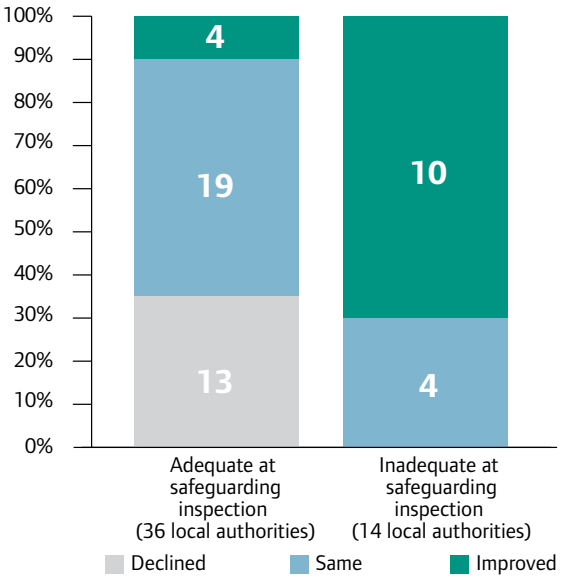


FIGURE 6 This chart compares those local authorities judged inadequate or adequate in the safeguarding inspections that took place between July 2009 and July 2012 with the outcome of child protection inspections that took place from June 2012 and July 2013 for the same authorities. The chart shows the numbers that improved, declined or remained unchanged for the 50 authorities that were inspected.

Source: Ofsted

32. Conversely, however, slightly more local authorities had improved (14) than had declined (13), including four who are now good (with some on a trajectory that may well lead to continued improvement). Change and improvement are indeed possible, despite the pressures.

33. The authorities who now hold an inadequate judgement are almost all different to the local authorities who held this judgement at the end of the first cycle, with only four who have been inspected for both safeguarding and child protection found inadequate in both inspections. We are not seeing persistently poor performance in the main, but clearly the fact that there are many authorities with such poor performance must be addressed. In those places judged inadequate for child protection, our inspections found evidence that children and young people continued to be harmed or were at risk of harm in their families, despite known concerns and in some cases where they had been identified as children in need or in need of protection.

Why is only good child protection good enough?

We would expect that:

- an adequate authority would identify serious risks, but a good authority should do it quickly, assessing and managing risks more effectively
- an adequate authority would have thresholds to decide who needs help, but in a good authority these would be better understood and focused on the help children need and from whom rather than whether the criteria for help are met
- an adequate authority would have a range of people working with a family in difficulty, but a good authority would recognise and intervene quickly when the risk to children becomes too great
- social workers in an adequate authority would work with a family, but in a good authority this should mean engaging the family in a genuine relationship with clear purpose and boundaries
- an adequate authority would complete assessments, but in a good authority these would reflect real risk, leading to better decisions about whether to intervene or not, and decisions that are regularly reviewed.

Performance in services for looked after children

34. Ofsted's inspections of services for looked after children concluded in July 2012. At that time, services for looked after children were stronger than in child protection, with a little over half being judged good or better. We have recently returned to reinspect services for looked after children in five local authorities who were either previously found inadequate in this area or recently judged inadequate in child protection. In all five authorities, the judgement for looked after children was the same as the judgement for child protection.

35. It is clear, therefore, that the conditions that enable improvement or that lead to decline or persistent poor performance apply equally, regardless of the service in question. Child protection is a particularly challenging area for many local authorities. In this regard, these inspections provide a sharper focus on where things can go wrong, and on what it takes to put them right. In Ofsted's inspections from this point forward, all children's social care services will be inspected through a single inspection framework.

Overall effectiveness of services for looked after children

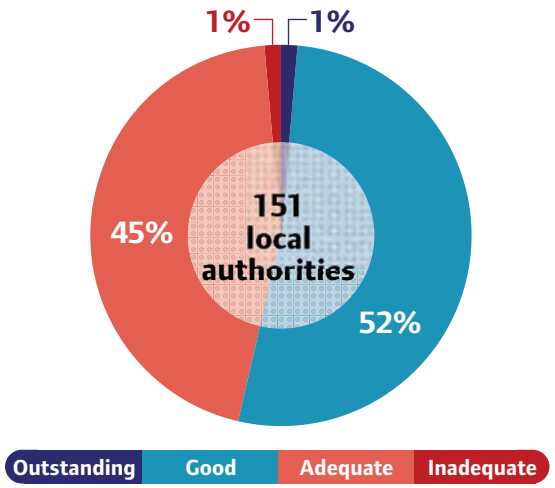


FIGURE 7

These inspections took place between July 2009 and July 2012.

Isles of Scilly did not receive a looked after children inspection.

Percentages in the chart are rounded and may not add to 100.

Source: Ofsted

Why local authorities change – or not

36. Local authorities have responded to the call for change, but the evidence from those authorities most recently found to be inadequate suggests that an intense focus on change can, with the wrong execution and without a clear understanding of what needs to change, result in a drop in performance. Of 17 local authorities recently found inadequate, the context prior to inspection was that:

- 11 had had a recent change in the director of children's services
- 12 had had another major change in leadership, either chief executive, lead member, independent Local Safeguarding Children Board chair or other senior management figure
- seven had been found inadequate in a previous inspection, of which three improved but then slipped again
- 11 were operating in a context of external pressure – either change in demand or demographic; wider council restructuring or budgetary pressure; poor cooperation from partners; or intense media scrutiny.

37. In this context, we are concerned about reports that, in the past year, 32% of local authorities saw at least one change in the post holder of director of children's services in the course of the year, with some local authorities seeing multiple changes in the post holder in a single year.[26] A persistent absence of stable leadership was a feature of most inadequate local authorities. Changes in leadership as a response to poor performance made sustainable improvement difficult, hampering action to address serious system and practice failures.

> **"There have been resource issues in the team and thus subsequent delays for some children. The absence of managers above team manager level with related experience is significant."**
> *(IRO views from adoption survey)*

How change can fail to deliver improvement

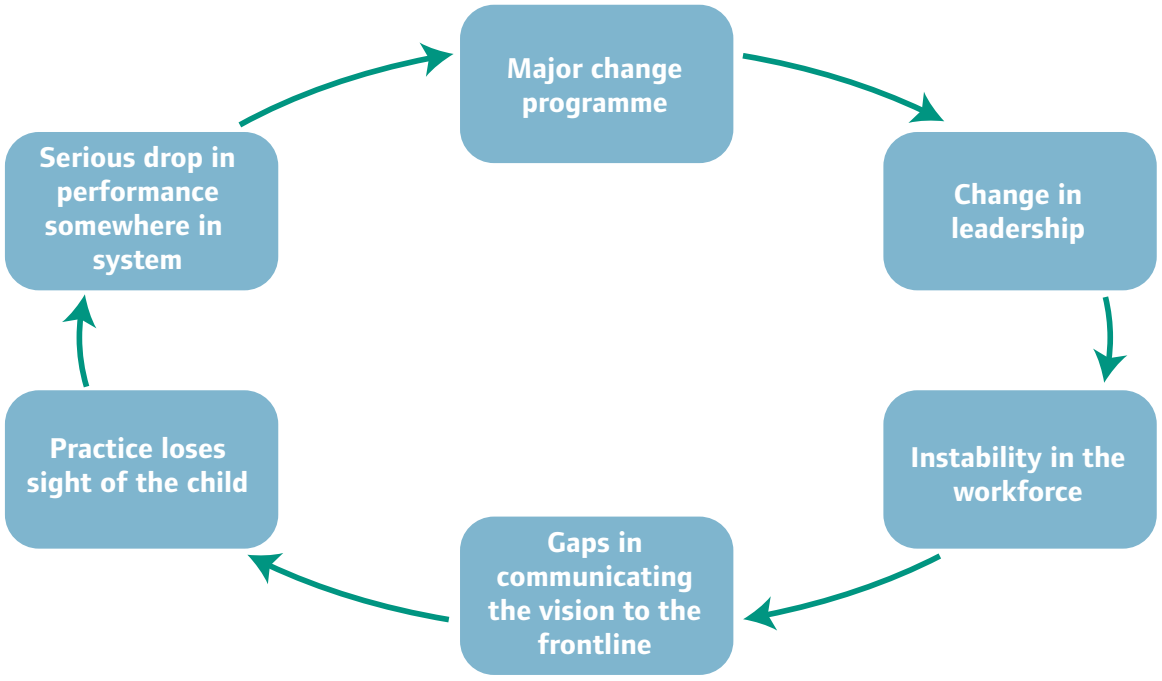


FIGURE 8

Source: Ofsted

26. ADCS email to Ofsted, August 2013.

> **There is a lack of skilled management oversight in the current service provision.**
> *(IRO views from adoption survey)*

38. In inadequate authorities, inspectors saw little evidence of strong leadership. There was no sense in these places of a vision shared by front-line staff or key partners. Expectations about performance were unclear and relationships with statutory partners, both professional and strategic, were underdeveloped. This often resulted in an uncoordinated approach to planning and delivering services for children and families that had a direct impact on the quality of practice at the front line.

> **They do not listen or acknowledge concerns and in my opinion are professionally dangerous across the board from management down to workers. They are defensive and lines of communication between management and their team is muddled and unclear.**
> *(IRO view from adoption survey)*

> **I was not told anything about my foster family. It was a time of fear. I feel the LA could have told me stuff etc. There was time (5 days) for a visit to be arranged.**
> *(Children's views from fostering survey)*

39. In the weakest areas, the most basic acceptable practice was not in place. Supervision, management oversight of decisions, purposeful work with families and decisive action when children were at risk or being harmed were not consistently evident. The quality of assessment and planning was poor and the views of children and families rarely considered or used to inform the delivery of services.

40. Some inadequate authorities have serious gaps in performance data, particularly relating to the quality and impact of the work at the front line. Others had a wealth of management information but did not accurately understand the strength and weaknesses of their services. Leaders and managers often focused on quantitative measures at the expense of qualitative scrutiny about the extent of change in families or the quality of plans for children and young people. This sometimes led to misplaced optimism about the quality of services, which meant that some children were at continued risk of harm, despite the perception locally that services were performing well. In a small number of inadequate authorities, it was not at all evident that managers had a firm, shared understanding of what constituted good practice, making the management of risk at the front line and support for staff almost impossible.

> **My social worker did not tell me I was coming into care and didn't tell me anything about it.**
> *(Children's views from fostering survey)*

> **I only complain to my foster carers who are best in the world. I know if I complain to the department they would hold it against me. They are not a bit supportive.**
> *(Child's view from fostering survey)*

Ofsted's good practice report *High expectations, high support and high challenge* looked at the link between effectively supporting social workers and improved outcomes for children.[27] Where there were accessible and visible senior managers who enjoyed strong political and corporate support, organisational cultures were characterised by high expectations, high support and high challenge. Being well supported enabled front-line staff to feel less worried and more confident about the risks they were managing and to become more focused, clear sighted and assertive. Scrutiny was welcomed as a key component of support; it made staff feel safer and appreciated for their good work. As a result, inspectors found that front-line staff were very motivated to engage families effectively in child protection plans. They were confident about asserting children's needs and clearly stating what needed to change. Parents responded to this by trusting their social workers and collaborating with them. As a consequence, children and young people became safer, less anxious and happier.

> **"I have been doing a pathway plan with my social worker which is helping me to plan for the future."**
> *(Child's view from fostering survey)*

How local authorities are getting to good

41. In a climate of turbulence for children's social care, many local authorities have been unable to improve their practice. However, some authorities have worked hard to ensure that their services are more effective and better able to meet the needs of the children and families in their area, which is leading to improved outcomes. Although these authorities set out on their improvement journeys in a variety of ways, there are a number of striking similarities among the key elements which ensured the success of their plans.

> **"The last 2 months has been quite an ordeal letting go of my son to the care of others and at times I have found it extremely difficult but the staff have been wonderful and they will make the time to listen I know if only for a short time he will be there until he has to move, that he is in the best possible place I couldn't have chosen a better place for my son or better staff to look after him."**
> *(Birth parent's view from children's home survey)*

42. These authorities spent considerable time, energy and focus in understanding front-line practice, in assessing what needed to improve and in ensuring that there was a coherent and urgent plan to address the identified areas of need. The quality of social work practice and direct work with families was at the heart of their change programmes. Virtually every local authority visited by Ofsted last year stated its commitment to improvement, but a commitment alone is not enough and the more successful authorities recognised this. In one area, for example, a senior manager met and got to know front-line staff, establishing what the issues were and engaging with social workers so that managers leading the improvement work had a clear understanding of what was going on at the front line. In another area, a senior manager audited every open case in detail, alongside the social worker, to gain a clear understanding of what needed to be done. Where additional resources were needed, elected members ensured that these were provided as a priority and used creatively.

43. Once these authorities had identified where their deficits were, they developed improvement plans with short-term milestones to address issues swiftly and drive up performance. One director of children's services explained how they would 'tell and re-tell' the story of improvement to ensure a council-wide buy-in. All these local authorities were very clear with their staff about what 'good' looked like and what their expectations were in terms of performance. Poor performance was managed and practitioners who were not meeting expectations were helped to improve or moved away from direct work with families. They tailored training and development to suit the individual needs of staff members.

27. *High expectations, high support and high challenge* (110120), Ofsted; www.ofsted.gov.uk/resources/high-expectations-high-support-and-high-challenge.

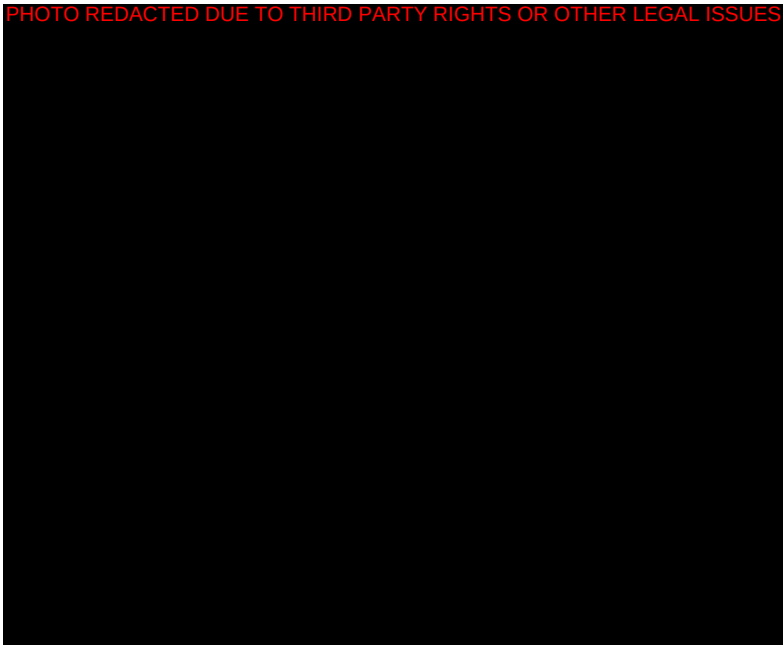
44. Staff in these authorities were determined to be good and to be seen as good; they became passionate about improving and developing a learning culture. This was achieved due to the very visible leadership; a clear belief in the ability of staff; and a shared responsibility across senior managers and elected members to prioritise improvements and make sure that they did what they said they were going to do.

> **I have been involved in consultations with senior managers fairly regularly over the last 18 months re training and development needs of staff… Managers have worked hard to ring fence appropriate training for both to improve service and with a view to better outcomes for children.**
> *(IRO's view from adoption survey)*

> **I felt that I was listened to by our social worker and my opinions taken into account.**
> *(Child's view from adoption survey)*

45. These authorities have not become complacent. In the words of one director of children's services, 'If you don't keep the focus on improvement then performance drifts backwards.' Each area has ensured, through a thorough quality assurance and performance management framework, that improvement becomes embedded and that all staff strive for better outcomes for children and families. Scrutiny ensures that any problems that develop are responded to quickly. Data and information are used intelligently to maintain a focus on meeting the needs of a changing population, and all are developing their staff within a learning culture. They retain a high-performing staff team within the authority.

> **Our Social Worker was very professional and experienced. She kept to task, was never late for appointments, went the extra mile to get info about the birth family and was honest/open and therefore supportive. An excellent service and as a result excellent future for our child because the match and work that went into it was so well done.**
> *(Adoptive parent's view from adoption survey)*



The performance of children's homes

46. We inspect every registered children's home twice yearly.[28] Since 2007, children's homes overall have improved their performance markedly. However, a persistent minority remain consistently weak, most often judged adequate, though occasionally dipping into inadequate in the past few years.

47. The sector should be commended for the general trend of improvement in meeting the minimum standards set by the government, but we are not satisfied that the standards are ambitious enough. What matter most are the experiences of children and young people and their progress, including the contributions that owners and managers are making to their education, quality of life and plans for the future. Using these criteria, inspection judgements are likely to be too generous.

48. The lives of many children who are looked after and who live in residential homes have been characterised by instability, inconsistent care and confusing numbers of adults who come in and out of their lives. They may also feel pain and conflict about their earlier experiences with their families. It is therefore not surprising that they

> **"Yes, I do find it hard to live with other looked after children but that's just life and I just get on with it."**
> *Child's view from children's homes survey*

> **"I would be happy if I knew what was happening to me."**
> *Child's view from children's homes survey*

> **"Staff are able to help me when I need it and they re able to understand what it is that I get upset about in the first place too."**
> *Child's view from children's homes survey*

Overall effectiveness of children's homes inspected

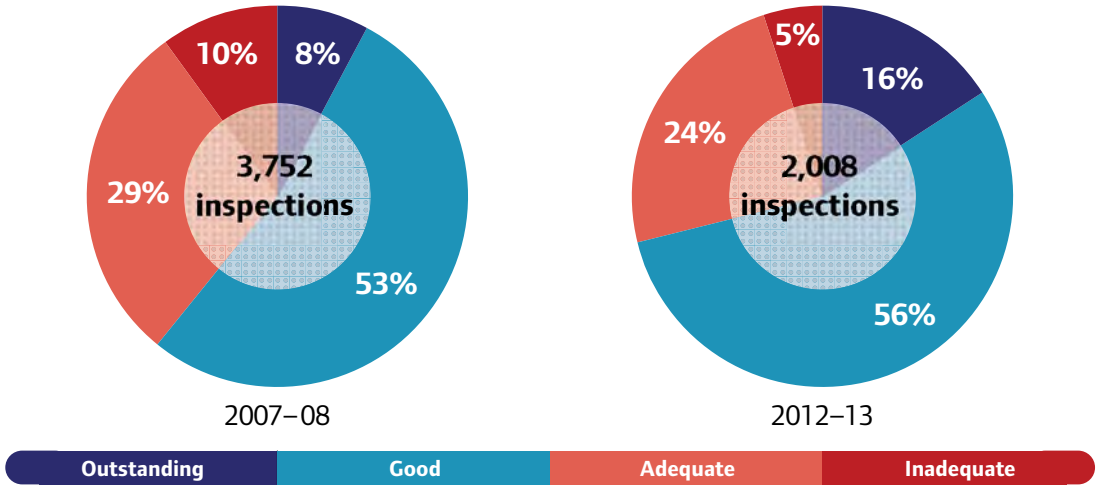


FIGURE 9

There are a number of differences between the two periods of inspection:

Data for 2007–08 include overall effectiveness outcomes for inspections of both full and interim inspections.

Data for 2012–13 include overall effectiveness outcomes for full inspections only. Interim inspections now only judge how each home has progressed since their last inspection.

There have also been framework changes between the two periods.

Percentages in the chart are rounded and may not add to 100.

Source: Ofsted

28. Subject to the home operating with children living there.

should display challenging behaviour as they seek to test the boundaries being set for them and the extent to which the adults in their lives will stay alongside them to help them to manage their difficulties.

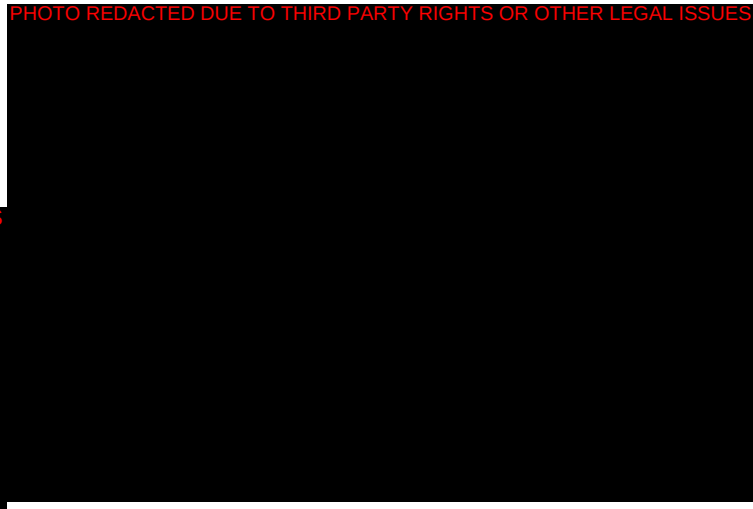
49. Ofsted is empowered to set requirements and recommendations for children's homes against the government's national minimum standards. The most common recommendation concerned the need to promote positive behaviour within the home. These recommendations relate to issues such as sanctions and rewards, discipline and managing conflict. The very high level of recommendations relating to behaviour management demonstrates that this is a priority area for improvement. Improvement action must include ensuring that specialist help is provided for children and young people whose behaviour is explicitly driven by earlier childhood abuse and neglect.

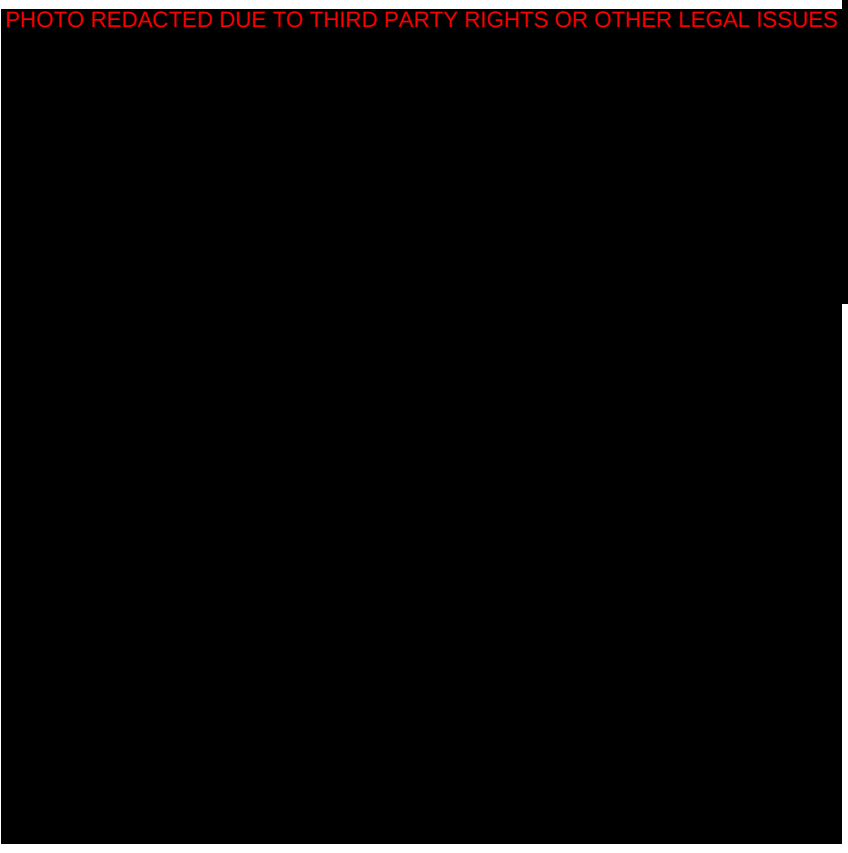
50. The most common requirement made as a result of inspections of children's homes in 2012–13 concerned the need to improve the regular and required reviews of the quality of care for children. Monitoring and evaluation of practice in poorer homes is insufficiently robust. This means that the poor quality of care can continue too long without challenge, potentially posing a risk to the children living there. Insufficient reflection on practice means that staff are less able to develop strategies for building relations with young people, which can lead to difficulties in managing behaviour and making the home a secure place to live.

51. We have reported before on our concerns about staffing instability in children's homes. Eighteen per cent of recommendations made in the past year related to employment and staffing issues. A common feature of children's homes that stay at adequate or become inadequate is weak management capacity. In a sample of children's homes that had been judged adequate for two inspections or more in succession, management weaknesses were central to their failure to improve. Often, this was the result of a failure to act quickly in replacing a departing manager; half of these homes had a new manager in place, not all of whom had been registered with Ofsted.

52. There is also an emerging pattern of managers being required to manage more than one home at a time. On occasions, inspectors have noted that this can result in a decline in quality, for example through a lack of effective supervision arrangements, and to low morale.

53. Given the risks presented by fragmentation, the extent to which children are being placed a long way from their friends and families is an area that must be carefully monitored.





> **I prefer to do my work on my own. But I know the staff are there if I need them. The home has even paid for private tuition in the home to help me in my maths GCSE. This has helped me massively.**
> *(Child's view from children's homes survey)*

Children's home places and children looked after, percentages by region

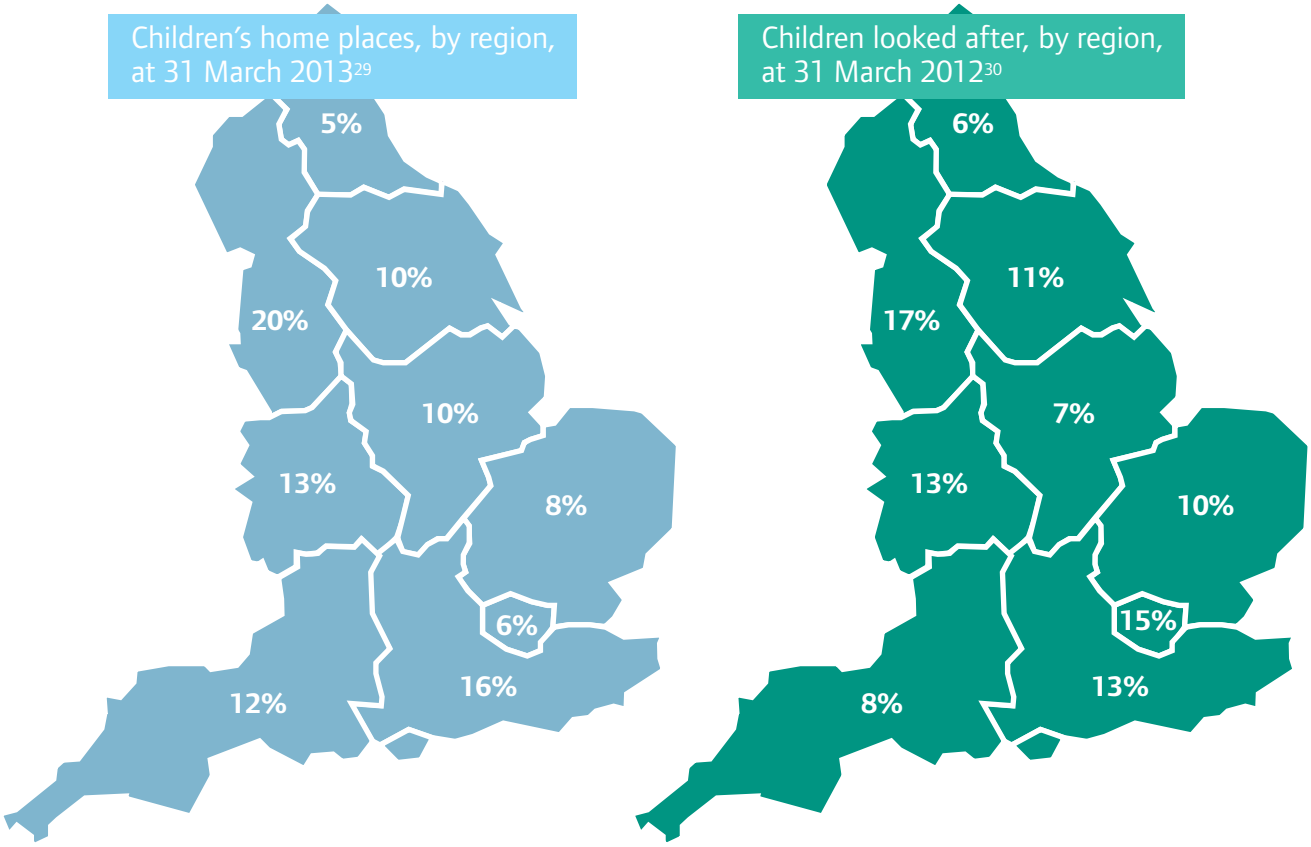


FIGURE 10 The Ofsted places data cover children's homes places, whereas the DfE data are for all looked after children, not just those in children's homes. The DfE data also relate to the regions where the children are from, not where they were placed.

Source: Ofsted and DfE

Ofsted will soon be publishing a report on the thematic inspection of looked after children placed out of area.[31] While inspectors saw some very effective work taking place to ensure good outcomes for children, in many areas corporate parents' oversight of the progress of children living far away from home was not robust enough. Some children living in other areas experienced considerable delay in accessing suitable education and, most often, the necessary support from child and adolescent mental health services. Too many local authorities did not routinely notify other local authorities that a looked after child was now living in their area. Despite the potential vulnerability for the high numbers of looked after children living far away from their families, independent reviewing officers did not always monitor and review plans closely enough or provide the necessary level of challenge to delay.

The performance of secure accommodation

54. Some of the most vulnerable children in society are those who live in secure conditions. The 16 secure children's homes in England care for children who are detained for their own safety and/or to protect the public. Nineteen full inspections have been carried out in the year, with two judged outstanding overall, 11 judged as good and six judged as adequate.

55. The most common weaknesses found in secure homes reflect the weaknesses in behaviour management in children's homes generally: poor recording of the sanctions, restraints and other methods of control applied to children, and weak oversight of these by independent persons. In contrast, the best homes are good at inviting external scrutiny, and have managers who check that practice is good and is helping children to manage the difficulties in their lives.

29. Children's social care providers and places (http://www.ofsted.gov.uk/resources/official-statistics-childrens-social-care-providers-and-places). **30.** Children looked after by local authorities in England, including adoption, March 2012 (https://www.gov.uk/government/publications/children-looked-after-by-local-authorities-in-england-including-adoption).
31. *Looked after children placed out of area* (130191), Ofsted; www.ofsted.gov.uk/resources/130191.

Just over half (51%) of young people surveyed from secure children's homes had experienced being physically restrained at the home. When asked about what happens after being subject to restraint, a quarter of young people (25%) responded 'no' when asked if they could see a nurse or doctor and almost a fifth (18%) responded 'no' when asked whether staff talked to them about the reasons for the restraint.

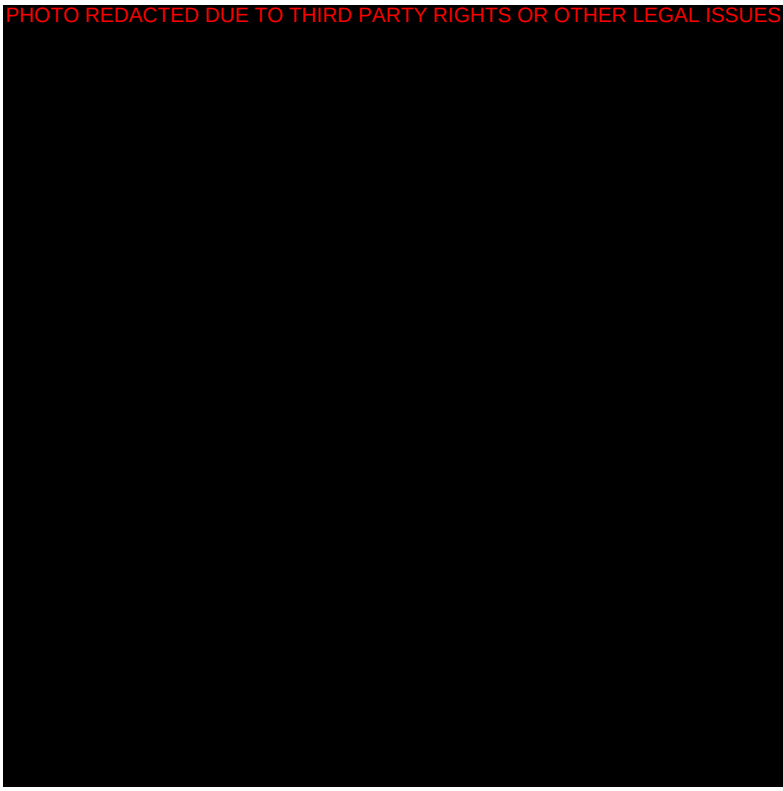
56. The most frequent recommendations for improvement concern:

    - the need to be better at preparing children for leaving the home
    - ensuring the suitability and training of staff
    - improving arrangements for searches of young people
    - applying sanctions, rewards and single separations in line with procedures to ensure fairness.

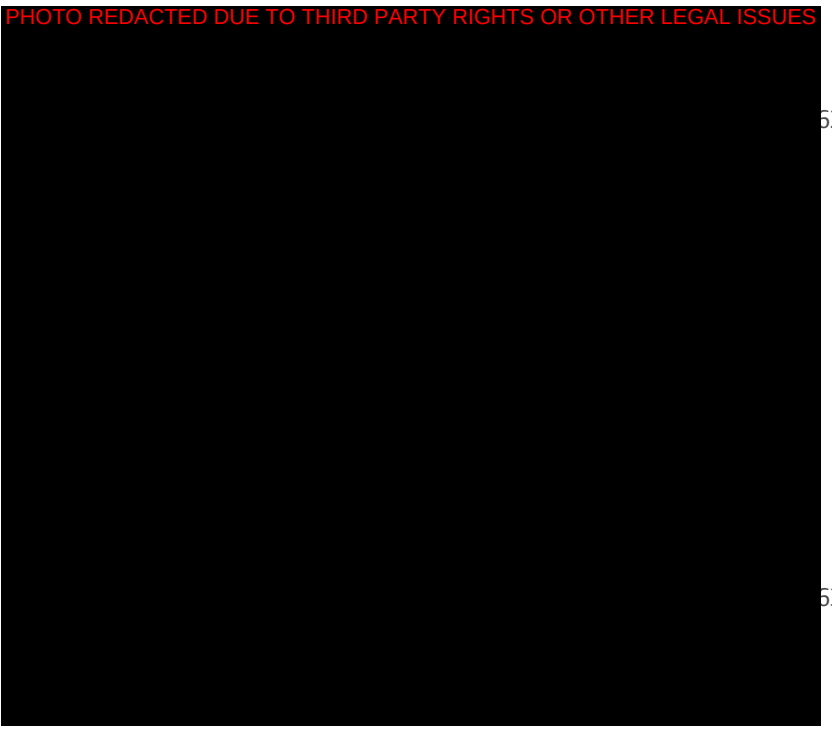
57. Some secure homes also need to make sure that children can complain and can see an advocate, that their views are heard and that their health needs, which are often complex, are met promptly.

28% of young people in secure children's homes were negative about the support they receive with their work or education, 21% answered negatively when asked whether they are encouraged to exercise and 23% said that they are not helped to participate in after school activities.

58. During the year, Ofsted piloted and then implemented a new inspection framework for the four secure training centres in England. All have now had a full inspection. These inspections are led by Ofsted but include inspectors from the Care Quality Commission and Her Majesty's Inspectorate of Prisons. All secure centres were judged good overall and increasingly use individual risk assessments to determine the need for searches and the use of handcuffs, with better consideration of young people's dignity. The centres continue to reduce the frequency and duration of restraints, and there is more independent oversight of the circumstances in which restraint is used. This is critically important, particularly given the grave consequences of poor restraint practice in the early days of secure training centres.



I think the reason why I get restrained is because nobody listens to me so I don't get to explain and sometimes I don't feel safe when being restrained. *(Child's view from secure children's homes survey)*



59. Other recommendations have led to greater internal and external management oversight and scrutiny of front-line practice. All of this is improving young people's safety. Given the very low starting point of many learners, the quality of education is highly significant, with two of the secure centres being good, one outstanding and one adequate. The weaker education services require improvements in the quality of teaching and learning, the curriculum, pupils gaining accreditation, vocational learning opportunities and data analysis to ensure that differences in outcomes for learners are reduced.

60. Good work is being undertaken to address young people's difficult behaviour and to ensure that this work continues in the community when they are discharged. The centres do their best to ensure that young people have somewhere to live and a school or college to attend in the community. They challenge the frequent reluctance of colleges to accept those released from custody, but there is more to do to ensure that all young people released from the secure centres can continue their education swiftly.

61. Future inspections will take account of the recent launch by the Care Quality Commission of standards for the healthcare of young people in secure settings, and government-led changes to restraint techniques across the sector. These changes allow for pain-inducing holds, currently not used at any secure centre. This additional focus in inspections will be important to ensure that young people are kept safe and not hurt unnecessarily.

The performance of adoption and fostering services

62. Outcomes for looked after children achieving permanence are improving. The number of children securing permanence through special guardianship continues to rise, but too many children and young people face delays in securing a stable and loving family. The number of children adopted during the year ending 31 March 2012 shows an increase of 12% from 2011,[32] but the process of adoption, particularly for older children where adoption is the best outcome, continues to take too long. Factors contributing to delays in the adoption process were highlighted in the Ofsted thematic report *Right on time: exploring delays in adoption*[33] and included a shortage of potential adoptive parents and delays in court processes.

63. The good and outstanding adoption and fostering services that we inspected were managed by strong and effective leaders who demonstrated a commitment to providing quality services, personalised planning for each child and to processes that placed children at the heart of all decisions made. Partnership working was a key strength in these services.

> **30% of the Adopters that responded to our survey were negative when asked if the way in which the adoption agency operates helped to ensure a prompt placement. 20% of partner agencies and foster carers responded negatively when asked if the adoption agency minimised delays to children being adopted.**

> **There is a lack of liaison with both the social worker and foster carer before a child is placed in relevant publications for adoption. This is a serious concern of mine as it causes unnecessary delay.** *(IRO's view from adoption survey)*

32. *Children looked after by local authorities in England, including adoption 2012*. **33.** *Right on time: exploring delays in adoption* (120010), Ofsted, 2012; www.ofsted.gov.uk/resources/right-time-exploring-delays-adoption.

Overall effectiveness of adoption and fostering services agencies during the last full cycle of inspections

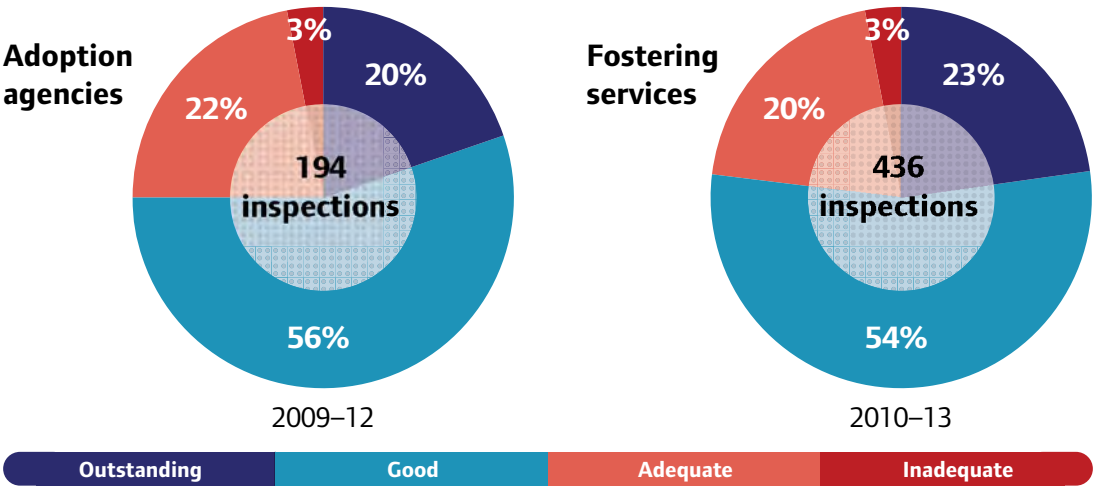


FIGURE 11 Data from the most recent respective three-year cycles of inspection. Percentages in the chart are rounded and may not add to 100.

Source: Ofsted

> …my child is from an Irish traveller heritage and I have received a pack which helps me explain the child's culture to him.
> *(Foster carer's view from fostering survey)*

> …but they didn't tell me they would take nearly a year to get around to going to court from when they said my new mummy and daddy would get to keep me.
> *(Child's view from adoption survey)*

> It could be improved if more of the children's social workers got to know their children better.
> *(Foster carer's view from fostering survey)*

> The adoption team have done very good work in preparing children to move on to their adoptive family. They have also got CAMHS involved in this early when needed.
> *(IRO's view from adoption survey)*

64. Weaker agencies were characterised by inconsistent management and poor monitoring arrangements and decisions often demonstrated a lack of urgency in securing the best permanence option. Weaker services were found to give insufficient attention to listening to the wishes and feelings of children and young people and were not using children's feedback to influence their plans or services. Management oversight of these services was often inconsistent and foster carers did not routinely benefit from effective training. This impacted on the quality of care offered to children and young people.

> **One child has real self esteem issues. I have asked for some literature for reading to support her. Months later I am still waiting!** *Foster carer's view from fostering survey)*

65. Currently, more than seven out of 10 adoption and fostering agencies are judged to be good or better. As regulated settings, these judgements are made in the context of national minimum standards. The new single inspection framework will result in a step-change in inspections of adoption and fostering services. The majority of adoption agencies and a third of fostering services are run by local authorities. Inspections will recognise that regulated elements of local authority services are part of a single service. Inspections will have a sharper focus on the experiences and progress of children and young people, including agencies' timeliness in securing the right permanence outcome for children who cannot live with their birth families. It is our expectation that this will set a significantly higher bar for all adoption and fostering services, whether run by local authorities, voluntarily or privately.

> **You must be joking! We rarely get good comprehensive information on the child before they come. Twice I have been out and out lied to and when I challenged the Social Worker they said they knew if they had told me the full story that I would not have taken the child. Both placements ended badly.** *(Foster carer's view from fostering survey)*

The performance of Cafcass

66. In the last year, Cafcass has focused much of its attention on children subject to public family law proceedings, ensuring that children's guardians are able to advise the family court in care and supervision cases. During 2012–13, care applications rose by 8% from the previous year to 11,064. In the same period, applications concerning private family law litigation rose by 9.5% to 45,804.[34]

Public and private family law

Public family law is that part of family law that regulates relationships between parents, or those with a parental role, where the state needs to be involved. This ensures that a child does not suffer significant harm. Court proceedings are usually initiated by a local authority applying for a care or supervision order. This may result in the child being looked after by the local authority under a care order. Adoption-related applications are also normally public law proceedings.

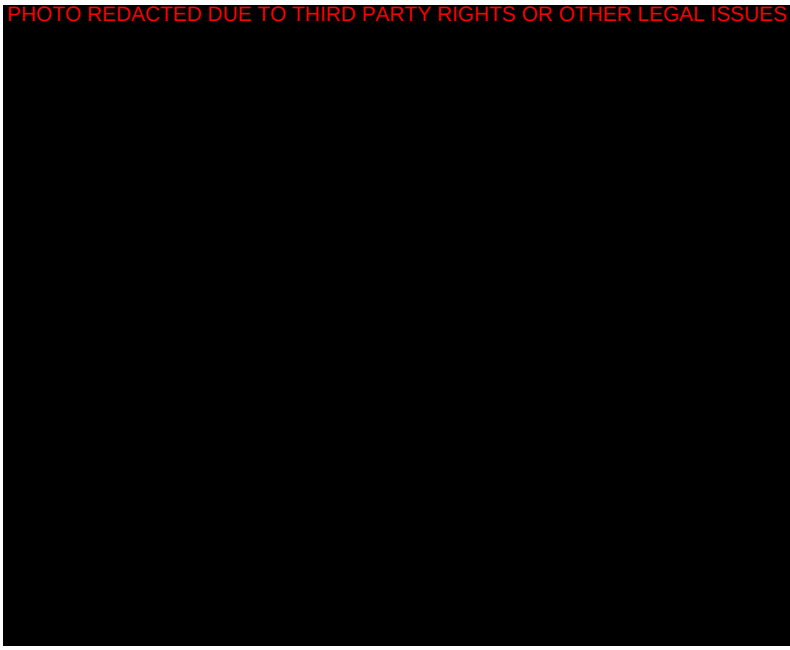
Private family law cases are dealt with through what is known as The Private Law Programme. This is designed to provide a framework for the consistent national approach to the resolution of issues in private law proceedings. It is designed to assist parties to reach safe agreements where possible; to provide a forum in which to find the best way to resolve issues in each individual case; and to promote outcomes that are sustainable, that are in the best interests of children and that take account of their perspectives.

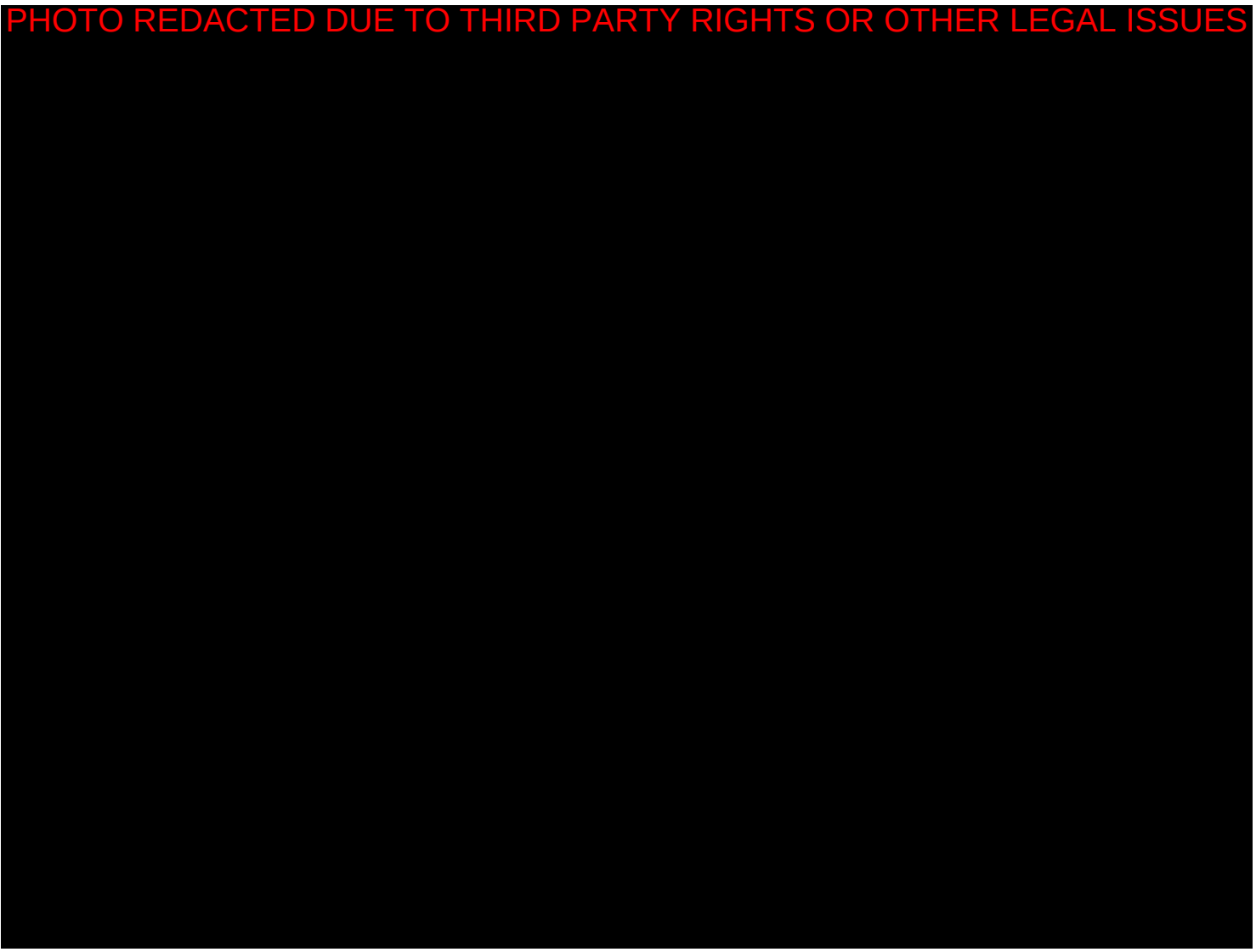
67. In March 2013, Ofsted completed the four-year inspection programme of all Cafcass service areas. Initial evidence showed weaknesses in safeguarding practice, particularly in cases concerning domestic violence, the effectiveness of management oversight of practice, and the consistency of compliance with policy and guidance. In seven of the first eight inspections (2009–10), the overall effectiveness was judged to be inadequate. Throughout 2011–12, Cafcass focused its efforts on refreshing its senior leadership team and making significant changes to the workforce, with a substantial turnover of social work practitioners.

34. *Annual reports and accounts 2012–13*, Cafcass, 2013; www.cafcass.gov.uk/leaflets-resources/organisational-material/reports-and-strategies/annual-reports.aspx.

68. The inspections undertaken in 2012–13 identified some consistent strengths. In each area, a new and effective senior leadership team was in place and they had accurately evaluated their strengths and weaknesses and identified the right priorities and were actively working on them to improve the service. By the end of the year, these priorities were delivering the planned improvements. Case planning and case recording, however, continue to be inconsistent and need to improve. While management oversight of practice has improved, work remains to ensure that it is consistently effective across all areas of practice.

69. Ofsted recently undertook consultations about inspecting Cafcass during 2013–14 through a single national inspection of the whole organisation, which met with support. The national inspection will raise the bar as we will test how effective Cafcass has been in translating improvement to 'good' consistently across the organisation.

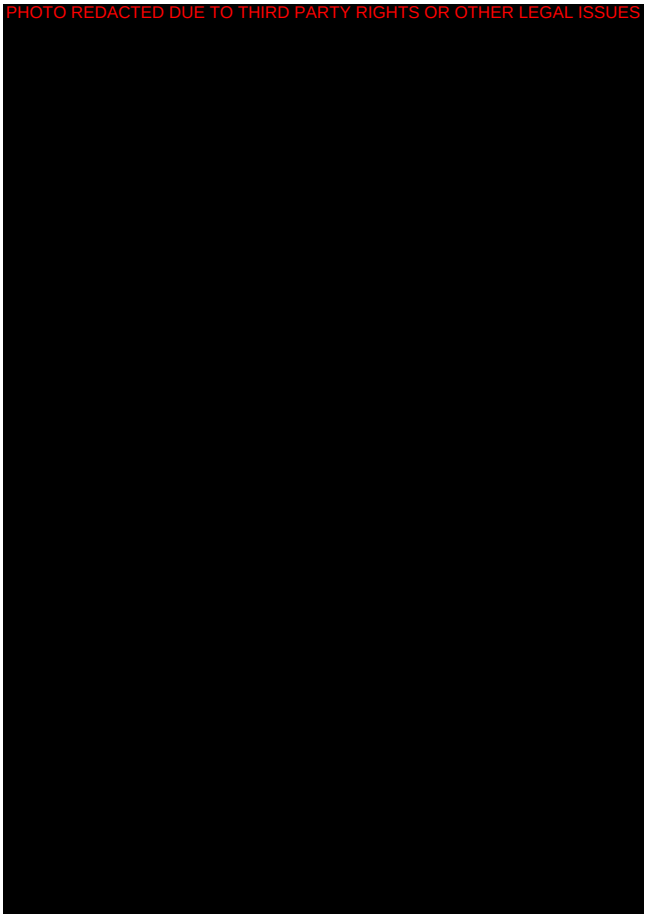


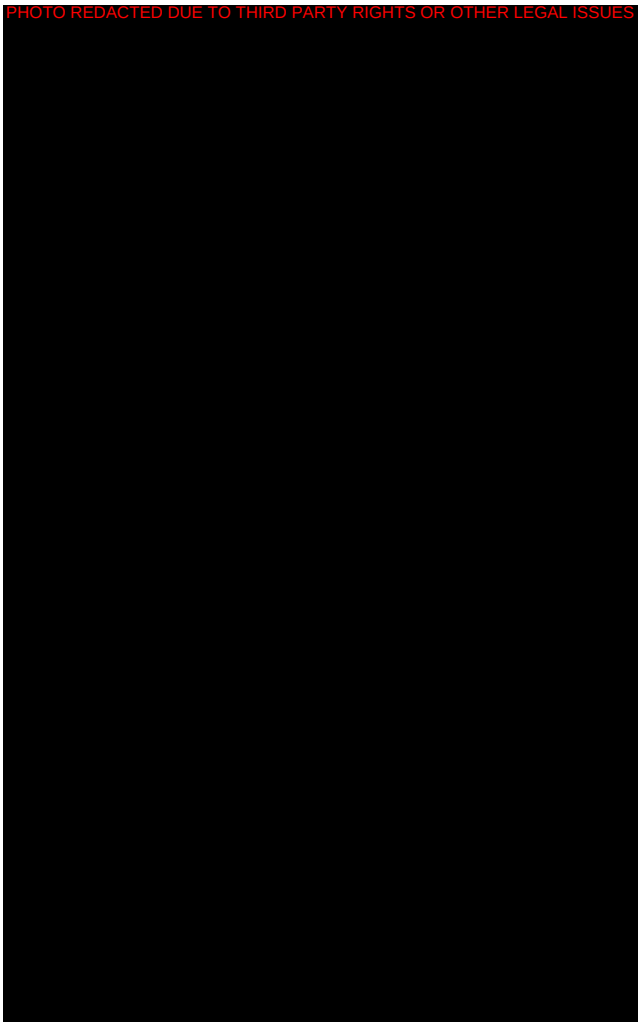


Our vision for the year ahead

70. The year ahead will see considerable change, both to our inspection and our approach outside inspection. First and foremost, we will be rigorous in how we hold local authorities and regulated services to account. While we recognise the real pressures facing the sector, we also know that only good is good enough. All children deserve the quality of care that only good or better services provide. Unless we find evidence that children's lives are improving as a result of the contribution of those supporting them, we will judge that service to require improvement.

71. While we will be rigorous in holding others to account, we also recognise the need to improve the quality and consistency of our inspections. We will be as rigorous in reflecting on our own strengths and weaknesses as we are in our inspection and regulation. If our priority is delivering the best possible chances for all our children, then it is incumbent on us not only to identify what needs to improve but to take every possible step to make sure our inspection is designed and delivered with a focus on improvement.

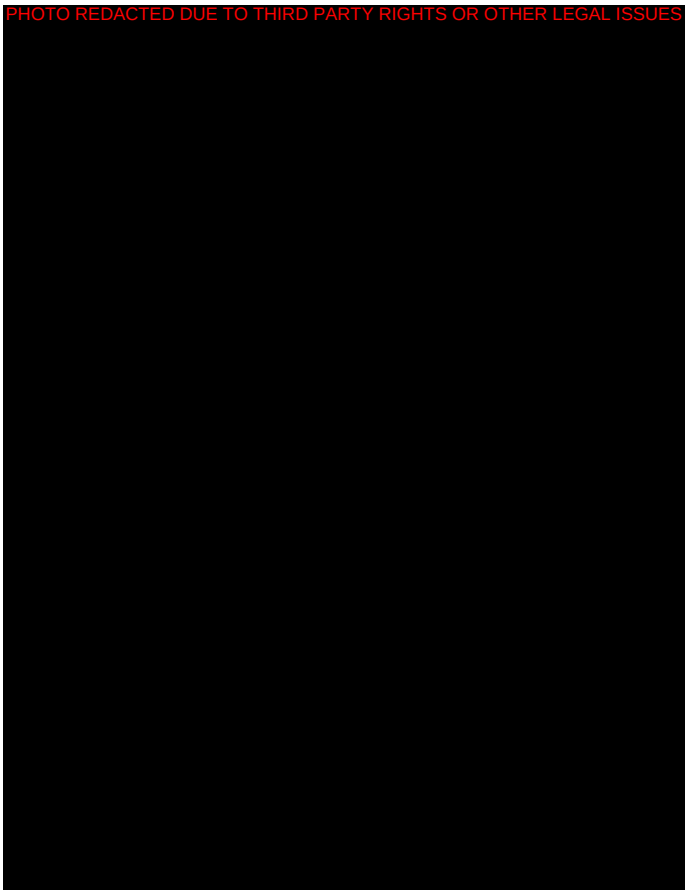


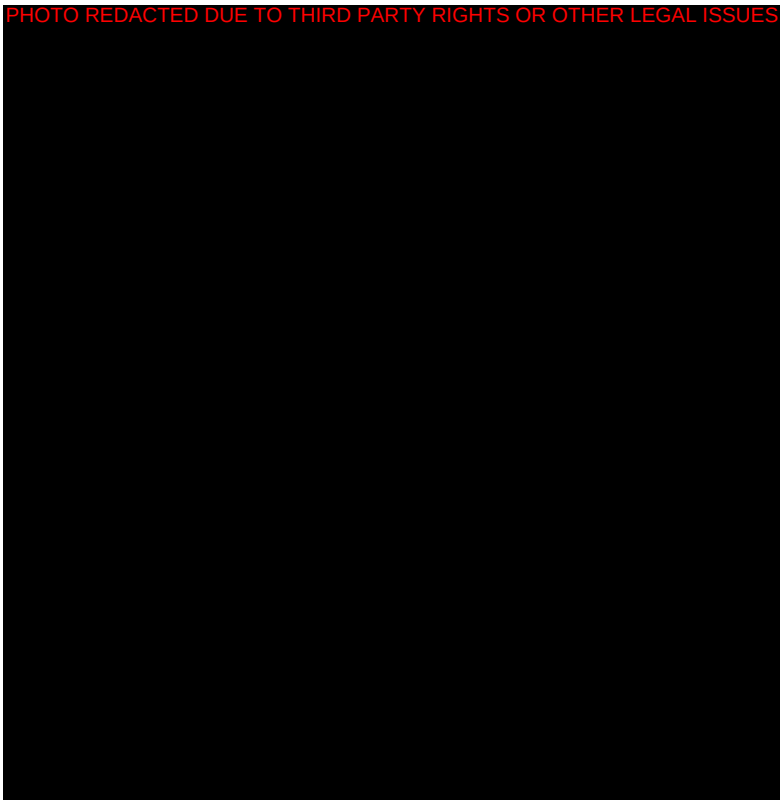


72. Equally, we must work with providers, local authorities and other inspectorates to ensure that our action is complementary in delivering improvement. Our new regional structure will enable us to focus on areas where progress and improvement for children, young people and families are not happening quickly enough. Where services are judged inadequate, we will host an improvement and challenge seminar. This will be followed by a monthly monitoring programme, reporting progress quarterly through the improvement board and advising on the timing of a progress inspection. Our regions will host a programme of seminars on national improvement themes. These will be offered to all authorities, but the main audience will be those who are inadequate or who require improvement.

73. In our pursuit of the success of each child, we will be re-shaping our inspection to place the child first. In whatever setting we find ourselves, all our evaluation will revolve around the question, 'What difference did that make to the child?' We will tackle the problem of fragmentation head on. This will mean evaluating the performance of the local authority end to end: from first contact to leaving care and everything in between. It will also mean reviewing the experiences of individual children regardless of where they are living. Where, previously, inspections of local authorities and the places looked after children live were completely separate, we will now be following individual children's progress in children's homes when we inspect local authorities. Because of the critical importance of coordinated action, Local Safeguarding Children Boards will also be the subject of a review, aligned with the inspections of local authorities.

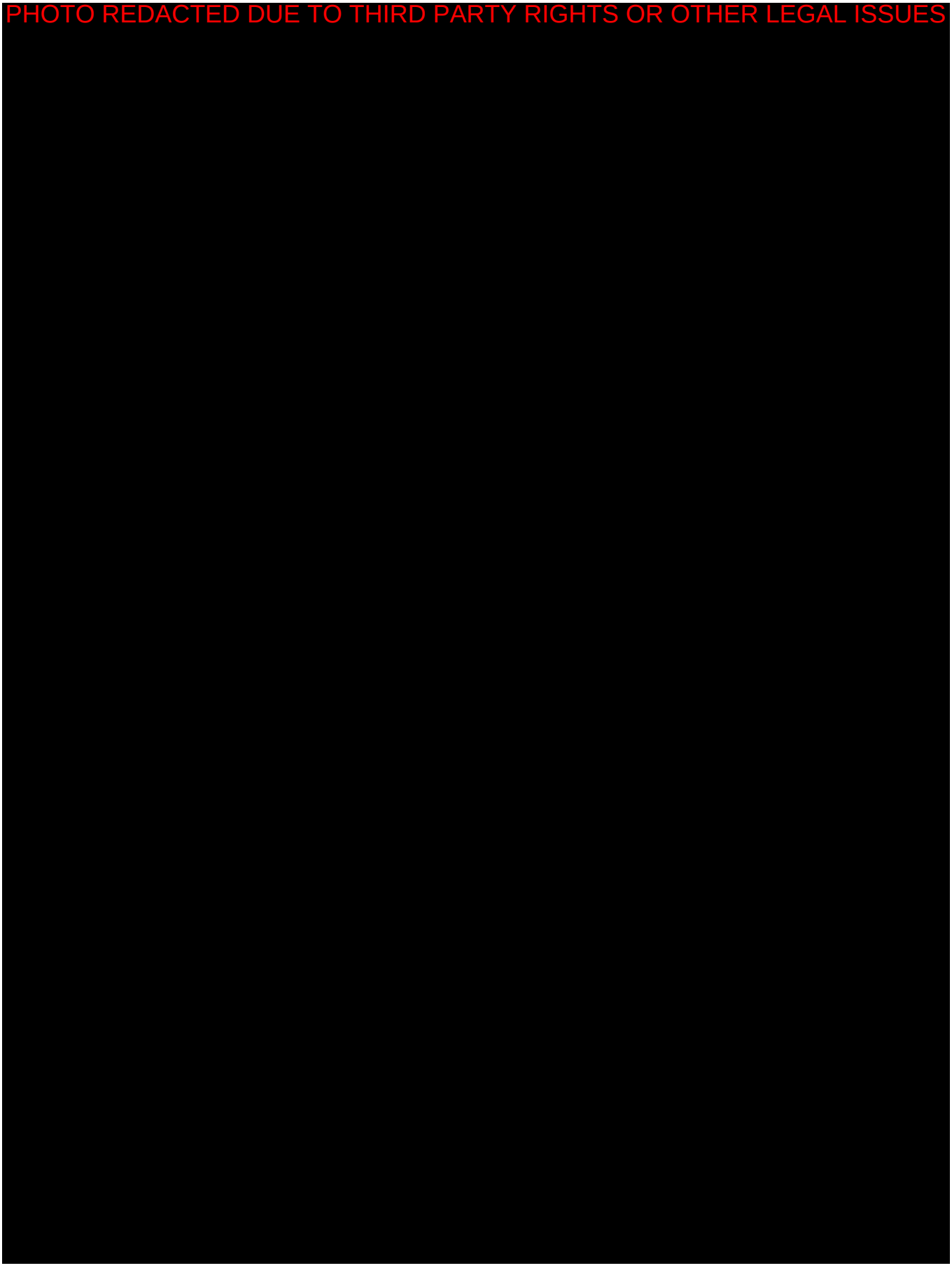
74. For children living in residential care, the extent to which they are cared for and kept safe will be more closely examined. Registered providers and responsible individuals operating children's homes will be expected to give a more specific account of how they protect children and invest in their future. We will test the extent to which they are providing specialist help, responding comprehensively when children are missing, and actively pursuing children's educational achievement.





75. In parallel, we are working with the Department for Education to strengthen the legislative and regulatory requirements for children's homes. This will improve our ability to remove inadequate care quickly from the system, and to hold providers to account for the qualifications and experiences of managers, as well as the provision of specialist care for the children for whom they have a lead responsibility.

76. Finally, we will continue to expand our understanding of the drivers of improvement and the barriers to change. We want to know more about the prevalence of abuse and neglect and the conditions that make abuse and neglect more likely. We will continue to ask questions about the progress that vulnerable children are making, and think about whether we know enough about how we define progress, measure it, and hold authorities to account for supporting it. We will test ourselves to see if our intentions for our inspection frameworks are being realised. We will continue to take steps to raise the profile and prestige of the sector. Wherever we see expertise, insight and skill that are improving lives and reducing the impact of abuse and neglect on the nation's children and young people, we will celebrate and share that success.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