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 our survey reports.

a. These data relate to inspections that took place between 1 April 2013 and 30 September 2014 for all providers, with the exception of single inspections of local authorities. For this framework the data relate to inspections that took place between 1 November 2013 and 31 December 2014. These data only include published reports.

b. Children’s homes consist of mainstream homes, secure homes and residential special schools registered as children’s homes. Residential special schools are registered as children’s homes if they care for children for more than 295 days a year.

c. Children’s homes receive a full and an interim inspection each year between 1 April and 31 March, except for those homes that are newly registered and for homes that do not provide care for children over long periods of time.

d. In 2013 the Cafcass inspection framework changed. We stopped inspecting individual Cafcass local service areas and there is now just one national inspection of Cafcass.

e. There are three branches of voluntary adoption agencies in Wales that Ofsted inspects because their head offices are in England. These are not included in this publication. There are also two head offices of voluntary adoption agencies included in these figures.

f. From 1 November 2013, local authority adoption agency inspections were absorbed into the single inspection framework. Five inspections were conducted under the old framework.

g. The inspections of local authority services for children in need of help and protection, children looked after and care leavers began in November 2013. They are referred to as the ‘single inspection framework’ throughout this annual report.

h. From 1 November 2013, local authority fostering services inspections were absorbed into the single inspection framework. Five inspections were conducted under the old framework.

i. Ofsted only conducts welfare inspections of boarding schools that do not form part of the Independent Schools Council.
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Commentary

As Her Majesty’s Chief Inspector of Education, Children’s Services and Skills, I am committed to using the power and influence of inspection to improve the lives of children and young people and especially those who are disadvantaged and vulnerable.

That’s why the inspection of children’s social care services is, in many ways, the most important and most challenging aspect of Ofsted’s work.

A sector under pressure

England’s children’s social care sector remains under intense pressure. The increasing demands on the system are stark. In the last year:

- the number of children in need increased by 5% to 397,600
- the number of child protection plans increased by 12% to 48,300
- the number of children being looked after by local authorities increased by 1% and is now at its highest level since 1987.

Stretched budgets are putting additional strain on these crucial services. Social care professionals are often expected to do more with the same or less, all the while knowing that the actions they take and the decisions they make can dramatically change the course of a child’s life.

Growing public scrutiny and criticism only adds to that pressure. I make no apology for Ofsted carrying out robust inspections of these services on behalf of the children and young people who use them. But we must recognise the context and constraints within which social workers and their managers work. They have a difficult and demanding role and do not always get the support and recognition they deserve.

A system in transition

The child protection system in England is in transition. Local authorities across the country are reforming their social care practice following Professor Eileen Munro’s ‘Review of child protection’ in 2011.1 As Professor Munro has pointed out, achieving the kind of cultural change required was never going to be easy and that is clearly reflected in inspection outcomes under Ofsted’s new single inspection framework, introduced in 2013.

We consulted widely on the single inspection framework and worked closely with the sector when formulating what we should expect of a good local authority. In doing so, we paid close attention to the findings of the Munro Review, the importance of the experiences of children, young people and their families and the value of high quality, professional practice.

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Under the new framework:

- inspections are carried out by larger teams and over a longer period of time than under previous frameworks
- inspections focus on the child’s journey, from early help to outcomes for care leavers
- inspectors now focus on observing practice, shadowing meetings and social work visits, scrutinising case files with appropriate workers and, most importantly, talking with more children and families
- we replaced the old ‘adequate’ judgement with ‘requires improvement’ to indicate our raised expectations.\(^\text{2}\)

I was pleased that Professor Munro found that we were focusing on the right areas of work and signalling the right ambition for children and young people in her review of the first 11 inspections under the new framework.\(^\text{3}\)

Ofsted has now completed inspections of almost a third of all local authorities in England against the new framework. Of the 43 inspections, 10 local authorities were judged good, seven were inadequate and the remaining 26 were judged as requires improvement.

The 10 good local authorities demonstrate what is possible. In these authorities, inspectors found high quality practice for families and children. This was the result of the relentless focus of senior leaders and managers on outcomes for children. These authorities have either responded well to the Munro review or were already acting in the child-centred way the review advocated. Either way, they are examples from which others must learn. In these authorities:

- social workers work directly with children and families at an early stage to prevent the need for further intervention
- managers and social workers have a discernible ‘grip’ on cases at all times
- management oversight of caseloads, vacancies and the quality of training and supervision is strong.

The 26 authorities judged to require improvement were not consistently demonstrating this kind of good practice across all their work. Some of these authorities had taken decisive action to improve from a low base. Others were delivering a good standard of service in some aspects of their work but not all. But across many of these authorities, inspectors found:

- a lack of coordinated and effective early intervention in families
- managers not overseeing practice consistently
- inconsistent support for social workers.


We are committed to supporting and challenging these authorities following their inspections to help ensure that they provide the consistently good level of service children and young people need.

We are particularly concerned that we found seven authorities to be inadequate. Inspectors found that in inadequate local authorities:

- children are left vulnerable or at risk due to a lack of coordinated and decisive action at a local level
- there was instability in the leadership and workforce, with high staff turnover and vacancy rates
- managers and leaders did not oversee practice with the necessary rigour.

Immediate action, including government intervention in places, was required as a result of the significant risks to children in these authorities.

As a proportion of all those inspected, the number of inadequate authorities is broadly in line with previous years. However, it is worth noting that it is not always the same local authorities that we find inadequate, with some declining rapidly. This is why it is important that the government ensures that there is appropriate oversight of local authorities between inspections, as the National Audit Office noted in its recent report.4

**Child sexual exploitation and children who go missing**

The importance of effective oversight of local authorities has been demonstrated very clearly in the last 12 months in a number of investigations into the terrible abuse of children in Rotherham.

The first of these, Professor Alexis Jay’s independent inquiry into child sexual exploitation, published in August 2014, was deeply shocking.5 It is clear that Ofsted’s previous inspection arrangements did not look at this issue in sufficient depth.

Such was my concern that I commissioned a thematic review of local authorities’ responses to child sexual exploitation.6 Based on a wide range of available evidence, including the experience of more than 150 young people, inspectors found that many of the authorities visited had not treated child sexual exploitation as a priority until very recently. Most were only starting to understand the extent to which child sexual exploitation was happening in their area.

Inspectors reported that the strong leadership required in this crucial area of child protection work was frequently lacking. As Professor Jay made clear, faced with such shocking crimes, senior leaders must show political and moral courage. They must never allow misguided beliefs about the impact for certain ethnic and cultural groups to get in the way of confronting this horrific abuse wherever it occurs.

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Children who go missing from care are disproportionately at risk of this
terrible abuse. That’s why I was concerned that, nearly two years after
Ofsted published a report on looked after children who go missing, we found
that some local authorities were still failing in their duty of care to these
vulnerable children.7

It is deeply disturbing, for example, that in the children’s homes inspected
as part of the thematic review, we found children and young people who
had been missing were either not having an interview on their return or
having one that was of poor quality. In these interviews, there was no clear
understanding of why the children had gone missing, where they had
been and what had happened to them while they were away. As a result,
intelligence was not captured properly at a local authority level and could not
be fed into children’s plans or shared with the police and other local partners.

Inspectors uncovered this kind of ineffective data recording and sharing
in too many of the local authority areas visited and across all the agencies
involved. The way in which many police forces collected data, for example,
did not allow for the effective collation of reported crime and prosecutions
specifically linked to child sexual exploitation. This meant that the
information the police shared with their partners was of limited value and
opportunities to build a picture of child sexual exploitation were missed.

That’s why Ofsted recommended in the report that local authorities,
the police and their partners must be required to report on all prevention,
protection and prosecution activity relating to child sexual exploitation in
a standard format. Only then will we be able to get a clear understanding
of the risks to children at a local and national level.

The importance of local oversight

The lack of joined-up information at a local level is indicative of weaknesses
in the bodies that are required to oversee local partnership working: Local
Safeguarding Children Boards (LSCBs).

LSCBs are charged with ensuring that local partners work together to tackle
safeguarding issues. So it is of significant concern that around three quarters
of the LSCBs reviewed to date have been found to be less than good,
including eight that were judged inadequate.

Evidence from our reviews suggests that the impact of LSCBs continues to
be hampered by their inability to ensure that partner agencies take decisive
action when weaknesses are identified. It is clearly the LSCBs’ role to identify
poor practice and advise the appropriate agency, but they do not have the
authority required to ensure that action is taken. They might, for example,
identify that the police contribution to strategy meetings is of poor quality
and inform the borough commander of their concerns. But my question is,
if nothing changes, who is responsible and what happens next? The LSCB
may well continue to report its concerns, but they do not have the teeth to
make sure things improve.

7  Missing children, Ofsted, February 2013;
I can only repeat here the recommendation that I have made in my last social care annual report: the government must clarify and strengthen the role and responsibilities of LSCBs to ensure effective and robust oversight and action at a local level.

**Strengthening inspection**

I cannot stress too highly the need for effective and constant oversight of all the services involved at a local level in safeguarding children.

Ofsted currently inspects local authorities every three to four years and, given the length of time between inspections, it would be wrong to rely on inspection alone to uncover significant failings. Of course, we will inspect sooner where local authorities are judged inadequate, or where serious concerns are raised and we are commissioned to inspect by the relevant government department. But that will not always happen where there is what Louise Casey in her report on Rotherham council called ‘a culture of covering up uncomfortable truths, silencing whistle-blowers and paying off staff rather than dealing with difficult issues’.

That said, I want to ensure that Ofsted does all in its power to help uncover such practice. Following the thematic inspection of child sexual exploitation, we have:

- further strengthened our focus on child sexual exploitation and children who go missing in all single inspections
- made it clear to inspectors that local authorities should be found inadequate if they are not doing all they can to identify and tackle these issues
- created a specialist team of Her Majesty’s Inspectors with expertise in child sexual exploitation to support inspections where it appears that the local authority is not effectively addressing the risk of child sexual exploitation
- worked with other inspectorates, including those of the police and health services, to develop a new coordinated inspection approach where concerns are identified.
- moved the delivery of the single inspection framework programme into our now well established regional structure to make the most of our local intelligence (from April 2015).

I hope these changes will help ensure that local leaders and frontline practitioners focus on these issues and that, as a result, children at risk of being sexually exploited receive the support and protection they deserve.

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Helping families early is essential

As Professor Eileen Munro highlighted in her review of child protection, ‘preventative services can do more to reduce abuse and neglect than reactive services’. That is why it is such a concern that, in many of the weaker authorities inspected, we found a lack of early, direct and coordinated action to support families as soon as concerns emerge.

When you look at how social care services are funded, that is perhaps no surprise. Currently, for every £1 spent on preventative early help services, local authorities spend a further £4 on relatively high-cost, reactive child protection. We have to ask whether that balance is right and whether more can and should be done to tackle problems before they deteriorate to a level where child protection intervention is required.

Over the last year, we have looked in depth at the quality of early help as part of a thematic inspection, the results of which we are publishing alongside this annual report. We found:

- serious weaknesses in the management oversight of early help cases, with a small number of cases having no formal management arrangements in place at all
- some LSCBs not monitoring the management oversight of early help practice
- local authorities and their partners not fully evaluating the impact of their early help work, focusing too much on process and compliance and not enough on the quality of the service and to what extent it was helping to improve children’s outcomes
- many partnerships lacking effective systems to evaluate whether the right children were receiving early help at the right time
- cases where children were not directed to the appropriate early help services and where, consequently, their circumstances deteriorated
- considerable variability in how well local authorities and their partners were sharing accountability and coordinating early help services.

The report makes several recommendations for local and national government, including the need to clarify the roles and responsibilities of the different agencies involved in early help provision. Without this clarity, partners will not always give early help the priority that it requires. This is something the government must address.

Despite these issues, the thematic inspection did find some very effective early help practice in the local authorities visited. Furthermore, the Department for Education’s Innovation programme and the Department for Communities and Local Government’s Troubled Families programme show what is possible when national and local government work closely together. We need to build on this and ensure that leadership at every level, including political leadership, demonstrates a renewed commitment to early help and support.

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Outcomes for children in children’s homes

I have already highlighted the lack of return interviews of children and young people who have been missing from children’s homes. This is a significant concern because these children and young people are disproportionately vulnerable to abuse and exploitation.

In many instances, they have already experienced abuse, neglect and trauma: they need stability and care more than most. The sad facts are that more than a third of these children continue to live in homes that are more than 20 miles from their family home and just under a third have lived in at least five different placements prior to their current one.

Ofsted inspects each of the 2,000 children’s homes in England twice a year. As we said in our last annual report, it has been a cause of frustration that the inspection of children’s homes has been built on national minimum standards that do not have sufficient aspiration for these children and young people and regulations that are concerned mainly with process and procedure.

Simply put, children’s homes can meet the current regulations without having to provide high quality care or good experiences for children and young people. As a result, Ofsted’s capacity to drive improvement in this sector has been limited to taking action to bring about compliance and to tackle inadequacy, including through closing down the very worst providers.

I am pleased, therefore, that the government has now introduced new regulations so that, from April 2015, our inspections will be able to focus more on outcomes for children and the quality of care they receive.

Under the current framework, the proportion of good and adequate homes has remained relatively constant, at 56% and 25%, respectively. Disappointingly, the proportion of inadequate homes has increased from 5% to 6% and the proportion of outstanding homes has reduced from 16% to 12%. Homes that are judged inadequate either improve or they close.

Homes that are good or outstanding are characterised by:

- strong leaders who know and understand the children and young people that live in the home
- staff who are committed to making a difference and who work closely with other agencies, including schools, colleges and the police, to ensure that children get the support they need
- a culture established by the Registered Manager that enables staff to support children, whatever issues may arise.

Conversely, in weaker homes, we have seen:

- changes in leadership that result in a dramatic decline in the quality of care provided to children and young people
- staff not tackling poor behaviour or setting appropriate boundaries
- staff not committed to looking for children and young people when they go missing and not taking appropriate action when they return.
A particular issue in this sector is the level of managerial turnover and the amount of time some children’s homes are without any manager at all.

To help tackle this, in July 2013, Ofsted made a policy change so that any home without a Registered Manager for 26 weeks or more would be judged inadequate for leadership and management and potentially inadequate overall.

Since introducing this policy we have seen a decrease in the amount of time that homes are without a Registered Manager: in December 2011, the average length of time was 41 weeks; in June 2014, it was 34 weeks; and by November 2014, it was 26 weeks.

**Recruitment and retention of social workers**

The continuing problems reported by local authorities in the recruitment and retention of social workers are also a cause for concern. In the latest ‘Safeguarding pressures’ research, the Association of Directors of Children’s Services (ADCS) reported that two thirds of authorities are experiencing recruitment and retention issues. Concerns raised in the research include:

- high staff turnover
- difficulty recruiting experienced social workers
- an associated increase in the use of agency staff
- the high proportion of newly qualified social workers.12

What’s more, there is a concern that these newly qualified social workers have not been sufficiently prepared for child protection work until recently. As Sir Martin Narey found in his review for the Department for Education, there are serious weaknesses both in the calibre of entrants to social care degree programmes – only 31% of undergraduates on social care degree programmes had one or more A level passes – and in the university courses they undertake.13

Recent action to address Sir Martin’s recommendations gives some cause for optimism. For example, the publication by the Chief Social Worker for Children of a ‘Knowledge and skills statement’, summarising what a new social worker must know, is a positive step.14 Frontline, a programme for social workers that welcomed its first cohort in 2014, is another reform that we hope will lead to improved practice and better identification and development of those with leadership potential.

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The need for strong and consistent leadership

Maintaining consistent leadership in children’s services is a challenge. In 2013–14, a third of local authorities had at least one change of director of children’s services during the year.

This level of volatility has been a cause of concern for some years. Of course ineffective leadership needs to be tackled but we also need to recognise and nurture those with capacity and potential. Over the last 12 months, we have looked in depth at the leadership of children’s social care services, with a focus on authorities previously found to be good or outstanding and those that had improved from inadequate. Our intention was to learn from these authorities but also to highlight their success in a sector that, all too often, focuses on short-term reactions to terrible tragedy.

We found that in these authorities there was a supportive but challenging professional environment. The leaders paid close attention to workloads and performance information, while also creating a collaborative environment with a set of common values and purpose.

Their success is a cause for celebration. The problems we face as a society and within the social care sector are manifold and entrenched. But I am clear that the strong and determined leadership of dedicated social workers and local partners can make all the difference, particularly where they are not afraid to act at an early stage.

We now all need to work together to make sure this exceptional practice becomes common practice. The cost to children, young people and our society as a whole is too great to get this wrong.

Executive summary

1. Since Ofsted’s last social care annual report,16 there have been over 5,000 inspections of children’s services providers, including over 3,000 children’s homes inspections17 and 43 inspections of local authority services for children in need of help and protection, children looked after and care leavers, under our new local authority single inspection framework introduced in November 2013.18

2. Ofsted now judges local authorities against tough new criteria that reflect the reforms asked of the system by the Munro review of child protection in 2011.19 These reforms are not quick or easy to make because they involve improving the fundamentals of professional practice, making informed use of professional judgement and focusing on the child at all times. Ten local authorities inspected under the new framework have been judged as good, seven were inadequate and the remaining 26 were judged as requires improvement.

3. The demand for local authority children’s services has been rising continually over the past seven years. In 2013–14 alone, the number of referrals to children’s social care services from someone who was concerned about a child increased by almost 11%, the number of child protection investigations rose by 12% and the number of children and young people becoming looked after rose by 1%.

4. Most of the resource available to local authorities to spend on children’s social care is spent on high cost services, helping children, young people and families once concerns about their safety and welfare have escalated to the level that triggers the statutory duty to assess and investigate. For every £1 spent on preventative early help services, local authorities are spending a further £4 on reactive child protection work.

5. Ofsted’s thematic inspections of early help and neglect found compelling evidence that children and young people living in complex and damaging circumstances were often waiting too long for help. If high thresholds for further investigation of concerns were not met, then it was often the case that families were offered no help at all.

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17 Full inspections.


6. Inspectors have seen evidence of leaders giving more strategic priority to the needs of children and young people who are at risk of, or subject to, sexual exploitation. However, services are not yet sufficiently alert to the nature and extent of the issue locally and the risks that children and young people face, nor are they suitably equipped to provide responsive services to meet their needs.

7. We are changing the way we inspect children’s homes to reflect the new regulations, which include quality standards, that are shortly coming into force. The average age of children and young people living in children’s homes is 14 and a half. Many of these have complex needs, so making a difference in their lives is a challenge.

8. Some local authorities are continuing to face difficulties in recruiting and retaining experienced social workers. This is resulting in high caseloads and weaknesses in frontline practice. Reforms to the social work profession are welcome but will take time to impact on the quality of services.

9. There is also increasing turnover among directors of children’s services, who play a critical role in stabilising and inspiring the social care workforce. Our inspection evidence points to the importance of strong leadership in motivating and supporting the workforce to improve their services to children and young people.
The services for children that Ofsted inspects

10. There were almost 3,000 providers of children's social care as at the end of September 2014.

11. Most of these providers are registered and regulated by Ofsted and are inspected by Regulatory Inspectors:
   - children’s homes (including secure children’s homes and residential special schools dual registered as children’s homes) – a full and an interim inspection on an annual cycle and additionally where concerns are identified
   - independent fostering agencies – inspection every three years and concern driven
   - voluntary adoption agencies – inspection every three years and concern driven
   - adoption support agencies – inspection every three years
   - residential family centres – inspection every three years
   - holiday schemes for disabled children and young people – inspection twice annually.

12. Regulatory Inspectors also inspect the welfare provision of residential special schools (annually) and other schools with boarding provision (every three years).

13. Her Majesty’s Inspectors conduct the following inspections:
   - local authorities – currently on a 3.5-year cycle, with re-inspections within the period if necessary
   - Cafcass – risk-based inspection currently every three years
   - secure training centres – inspection annually, jointly with Her Majesty’s Inspectorate of Prisons (HMIP) and the Care Quality Commission (CQC)
   - youth offending work – inspection annually, jointly with HMIP.

14. Her Majesty’s Inspectors also conduct reviews of Local Safeguarding Children Boards (LSCBs).
15. This report reviews the inspection evidence of agencies or organisations that were responsible for around 130,000 very vulnerable children and young people.

16. Since the publication of our last social care annual report, there have been a number of important developments to Ofsted’s social care work. We have:

- introduced a new local authority children’s services inspection framework that looks at the help, care and protection of children and young people
- introduced a ‘requires improvement’ judgement for this inspection
- introduced reviews of LSCBs, to look at coordinated action to support vulnerable children and young people
- piloted, through our regional structures, improvement and challenge seminars and monthly monitoring programmes for inadequate authorities
- started running a series of seminars on national improvement themes, available to all authorities but designed to help those who require improvement or are inadequate
- conducted thematic inspections on neglect, early help, assessment, leadership and child sexual exploitation
- started looking more closely at how children and young people are protected and how the sector responds when they go missing
- completed our first national inspection of Cafcass
- continued to improve the quality and consistency of our inspections.
Findings from inspections of local authorities

17. Since November 2013, there have been 43 inspections of local authority services for children in need of help and protection, children looked after and care leavers,20 under the single inspection framework. They give a thorough and in-depth understanding of those services.

Figure 2: Overall effectiveness judgement under the single inspection framework (%)

<table>
<thead>
<tr>
<th>Inspections (43)</th>
<th>Outstanding</th>
<th>Good</th>
<th>Requires improvement</th>
<th>Inadequate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>23</td>
<td>60</td>
<td>16</td>
<td></td>
</tr>
</tbody>
</table>

Percentages do not add to 100 because of rounding.

18. In our 2013 annual report, we stressed that only good or outstanding local authorities are likely to remain resilient when faced with the pressures of rising demand. The single inspection framework has new, more rigorous criteria to describe what good looks like for services to protect and care for children and young people. These criteria were developed in consultation with the sector and given strong support. Judgements under the new framework need to be seen in the context of the reforms in child protection that are being implemented following the Munro review.21 These reforms require authorities to improve the fundamentals of professional practice, moving from process and instruction to thinking about children and young people’s experiences and making informed use of professional judgement. In her review of the first 11 inspections under the new framework, Professor Munro recognised that we were focusing on the right areas of work and signalling the right ambition for children and young people.22 We know that these are not quick or easy reforms to make and that they are happening at the same time as reforms in the social care workforce, which are taking shape but not yet fully embedded.

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19. Another feature of the single inspection framework has been replacing the judgement of ‘adequate’ with ‘requires improvement’. This is consistent with changes to inspections of other provision inspected by Ofsted, including schools, and reflects the view that ‘good’ is the standard that we should expect for children and young people. It is important to note that, while not good enough, services that require improvement are not regarded as failing.

20. Under this new demanding framework, 10 out of the 43 local authorities we have inspected so far have been judged as good overall, while seven have been judged inadequate. Too many still require improvement and they, as well as those judged to be inadequate, will be helped to improve.

21. Inspection evidence shows that good local authorities have leaders and managers who focus relentlessly on the quality of professional practice and on providing effective services that make a difference to children and young people’s lives. In authorities that have been judged good:

- managers and social workers have a discernible ‘grip’ on cases at all times
- they know what is happening across their casework and the next steps they are taking
- there is usually an effective theoretical base informing the work and the approaches that social workers take in helping families to change
- assessments are of a high quality, focusing on the risks and needs of children and young people and leading to good decision making
- children and young people have a say in the plans made for them and their feedback is taken into account
- plans are informed by clear chronologies and a good understanding of the capacity of the parents to look after their children
- management oversight of caseloads, vacancies and the quality of training and supervision is strong
- a positive working environment for professional staff is prioritised
- poor performance is identified quickly and addressed.

22. Two of the local authorities we have inspected over the last year, Essex and Cambridgeshire, who had previously been judged inadequate, have now been judged to be good overall. These local authorities have demonstrated good leadership, a commitment to provide specialist early help for families and a strong focus on good practice. Their leaders have prioritised recruitment and cultivated an improved social work environment and there is effective scrutiny of casework decisions.
23. We have judged 26 local authorities as requires improvement under the new framework. There are no widespread or serious failures that leave children being harmed or at risk of harm in these authorities and the welfare of children looked after is safeguarded and promoted. However, these authorities are not yet delivering consistently good protection, help and care for children, young people and families. Some have started to take decisive action to improve from a low base. Others were delivering a good standard of service in some aspects of their work but not all. Across many of these authorities, inspectors found:

- a lack of coordinated and effective early intervention in families
- managers not overseeing practice consistently
- inconsistent support for social workers.

24. Ofsted is committed to supporting these local authorities to improve to be good overall. Our improvement offer draws on research and the wealth of evidence built up during inspection. We have piloted improvement planning seminars in four local authorities requiring improvement. Her Majesty’s Inspectors provide detailed inspection information to the authority to help them develop an effective and achievable improvement plan. The local authorities are then invited to a series of ‘Getting to Good’ seminars that focus on identified needs. Our inspectors also monitor progress with each authority after six months to help them stay on track.

25. Seven local authorities have been judged inadequate under the new single inspection framework. Common problems for these local authorities were:

- instability in the leadership and workforce, with high staff turnover and vacancy rates
- leaders and senior managers not paying enough attention to the quality of practice and the needs of children and young people
- insufficient oversight of practice by first line managers and independent reviewing officers
- little evidence of decisive action to keep children and young people safe
- poor assessment and planning.

26. Clearly, these local authorities require more intensive support. Ofsted has recently piloted monthly monitoring visits, quarterly progress reviews and a progress inspection of inadequate authorities. Early findings from the pilots in Northamptonshire and Cheshire East have been positive. Subject to the findings of a formal evaluation, we plan to roll out this programme of support nationally this year.
Reviews of Local Safeguarding Children Boards

**Figure 3: Judgements from Local Safeguarding Children Board reviews (%)**

<table>
<thead>
<tr>
<th>Inspections (43)</th>
<th>Outstanding</th>
<th>Good</th>
<th>Requires improvement</th>
<th>Inadequate</th>
</tr>
</thead>
<tbody>
<tr>
<td>28</td>
<td>53</td>
<td>19</td>
<td></td>
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</tbody>
</table>

* One review carried out under Section 20.

27. Ofsted now conducts reviews of LSCBs alongside its inspections of local authorities under the single inspection framework. These reviews look at how effectively the LSCBs carry out their statutory functions and monitor the quality of what is done by partner agencies to protect and care for children and young people. To date, just over a quarter of the LSCBs reviewed have been judged as good overall.

28. Evidence from these reviews shows that good boards tend to be characterised by mature partnerships that have been the basis for agreeing priorities and sharing resources. In these boards, responsibilities have been clearly articulated among the chair, the local authority chief executive and the director of children’s services. There are good strategic links between partners’ objectives and priorities and those of other key decision making bodies, such as the local health and well-being boards. The board and its partners typically share a determination to improve the quality of frontline practice, conducting section 11 audits, identifying weaknesses and challenging each other to improve.

29. Inspectors found that LSCBs requiring improvement did not regularly scrutinise the quality of practice and that their progress against improvement priorities was slower. Partners, particularly schools, were generally less engaged in the boards’ work. Weaker boards did not share clear performance data about children and young people who were missing or who were subject to or at risk of child sexual exploitation, despite this being a requirement of statutory guidance. These boards were less able to challenge how services were being delivered and consequently were not effective enough.

30. The evidence from our inspections and improvement work strongly suggests that some of the challenges facing LSCBs and their partners result from weaknesses in the accountability framework.

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23 Section 11 of the Children Act 2004 obliges key bodies to ensure that their ‘functions are discharged having regard to the need to safeguard and promote the welfare of children’ and that services ‘are provided having regard to that need’; www.legislation.gov.uk/ukpga/2004/31/section/11.

24 Statutory guidance on children who run away or go missing from home or care, Department for Education, January 2014; www.gov.uk/government/publications/children-who-run-away-or-go-missing-from-home-or-care.
31. The Children Act 2004 created LSCBs to coordinate local action to protect children and young people and ensure that multi-agency working was effective. They are responsible for monitoring the effectiveness of the local authority and the board’s partners to safeguard and promote the welfare of children and young people and for advising them on ways to improve. However, LSCBs have limited authority and do not have powers to require agencies to act. Each of the partner organisations that make up the LSCB has its own accountability structure and is inspected separately. There is no obligation on partner organisations to take account of the advice of the LSCB or to carry out any recommendations given by the LSCB. Evidence from Ofsted reviews suggests that their effectiveness continues, therefore, to be hampered.

32. Where local services for safeguarding children and young people are found to be inadequate, the weight of that judgement and the necessary improvement action falls most heavily on the local authority and the director of children’s services, rather than on the LSCB or its partners. However, the local authority itself has limited powers to direct others to take action.

33. Accountability for services is fundamental to improving the care and protection of children, but the current framework of accountabilities is not working.

34. The government needs to review where responsibility lies locally for protecting children and who should have the power to take decisive action if the needs of children are being compromised.
The rising demands on local authority children’s services

Volumes of children’s services activity are increasing

35. Between March 2010 and March 2014, the number of referrals rose by 9%, the number of child protection enquiries by 60%, the number of children subject to a child protection plan by 24% and the number of children in need by 6% (from 375,900 to 397,600).\(^{25}\)

In 2013–14, referrals by someone concerned about a child or family increased by almost 11%,\(^{26}\) meaning that some authorities may have had to support an additional 300–400 families, each needing assessment and help of varying complexity.

36. The number of children in need in England at any point during 2013–14 was 781,200, almost one in 15 children aged 0–17. The primary need at assessment for almost half of these children was abuse or neglect, with nearly a fifth being assessed as family dysfunction.\(^{27}\) Of the 145,700 continuous assessments that were completed during 2013–14, 41% recorded domestic violence as the most common factor, 25% recorded mental ill health as a key issue, 15% recorded alcohol misuse and 15% recorded drug misuse.\(^{28}\)

Figure 4: Volumes of referrals and assessments

![Graph showing volumes of referrals and assessments]

Data for 2008 and 2009 can be found in:


Data for 2010 to 2014 can be found in:


More children are being looked after

37. The number of children being looked after has increased steadily over the past few years and is now higher than at any point since 1987. The Children Act 1989 encouraged a culture of working with parents to help families stay together. By 1993, local authority interventions had become more sharply focused, with more children remaining with their own families. This created a substantial fall in the number of children becoming looked after (or entering care as it was then called).

38. As at 31 March 2014, 68,840 children were being looked after by local authorities in England, an increase of 1% from March 2013 and 7% since 2010. During the entire 2013–14 year, 97,950 children were looked after, an increase of 3% from March 2013 and 11% from 2010.

39. There was a rise in the number of those aged 16 and over who started to be looked after during the year, a 22% increase from 2013. Despite this increase, the most common age group remained the 10–15-year-olds, who made up 37% of the total number of children looked after.

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40. Most of the children looked after will have lived in more than one placement. Each year, one in 10 – around 7,500 – children experience three or more placement moves. Nearly 5,000 children and young people who ceased to be looked after in 2013–14 (16%) had experienced five or more placement moves during their time in care. This included children aged under four years old. Nearly 1,500 (5%) experienced 10 or more moves. This included children aged between five and nine years.

41. In 2014, just 12% of looked after children in Key Stage 4 achieved five GCSEs at grades A* to C, including English and mathematics, compared with 52% of the total cohort. The context is important: many children and young people living in care have been deeply traumatised before they entered the care system; around two thirds have a special educational need; and the amount of time children and young people live in care varies. However, while attainment gaps have narrowed slightly over the past few years, more could be done to improve these children’s life chances. Only 69% of looked after children attend a good or outstanding secondary school compared with 75% of children in the population as a whole.


The rising demands on local authority children’s services

Funding is under pressure

42. Of the £9 billion spent on children’s services by local authorities in 2013–14, £3.7 billion was spent on caring for children looked after. Figure 6 shows how planned and actual spending has not kept pace with the rising numbers of children looked after.

Figure 6: Children looked after financing from the Section 251 returns


43. It is likely that Ofsted inspections of local authorities will continue to identify unmet need and limited support for families and children, unless rising demand is matched by new resource or new solutions.

44. In 2013–14, £6.1 billion was spent on what is often described as ‘intervention’ or ‘specialist social care support’. The three largest costs for local authorities in this area include:

- £1 billion on looking after children living in residential children’s homes or residential special schools
- £1.5 billion on foster families for children looked after who are unable to live at home
- £1.7 billion on the social work system that makes and supports those decisions.38

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Helping families early

45. Providing early help is a way of giving support to children before they need more formal and intensive help from the child protection system. It can also help to stabilise families and in doing so can embed outcomes that sustain beneficial change, for example adults returning to work and children to school. The legislation that underpins the state’s relationship with families is founded on the key principle that families should be supported early and for as long as they need help, to prevent further coercive intervention in their lives. The statutory guidance for all professionals working with families – ‘Working together to safeguard children 2013’ – emphasises the significance of early support and the responsibilities of all agencies to identify, assess and provide this help. Only joint agency working can properly help address the multiple difficulties that some families face.

46. Our evidence on early help from the child protection inspections of 2012–13, the single inspection framework from 2013 and the recent thematic inspection of local early help provision shows that a number of local authorities have made good progress. However, overall, help is not offered early enough to families in many places and there is limited clarity about whose responsibility it is to help families early on.

47. ‘Early help – whose responsibility?’ found that just under two thirds of the early help cases reviewed, inspectors did not see effective planning and monitoring of the child’s progress. In the third of cases where there was effective planning and monitoring, there was evidence of children’s circumstances improving across a broad range of areas. These included:

- better housing and home conditions
- stabilised care arrangements
- faster progress towards the child’s developmental milestones
- better social skills, speech and language
- less inappropriate sexualised behaviour
- better school attendance and better behaviour, with fewer short term exclusions
- raised academic achievement.

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48. The identification of need was variable. Many local authorities and their partners did not have sufficient knowledge of the prevalence of drug and alcohol dependence in families, mental ill health, family violence, homelessness or numbers of children and young people missing from education or excluded from school within the local authority. Yet we know from all the available evidence that these issues are the triggers for, or indicators of, potential or actual abuse and exploitation of children and young people.

49. ‘Early help – whose responsibility?’ found that there was insufficient clarity about the roles and responsibilities of statutory partners and local agencies in this important area of practice. Although partner agencies are required to carry out their functions with the protection of children in mind, there is no requirement on any single organisation in a local area to provide help before the criteria for sections 17 or 47 of the Children Act 1989 are satisfied. LSCBs should publish a document that sets out the thresholds\(^{41}\) that apply in respect of the protection and care of children and young people, but this is not enough to ensure that agencies share resources and work together to provide preventative services for families. Indeed, in some places, inspectors found that thresholds acted as a barrier. In a significant number of these cases where the situation had deteriorated, children and young people were re-referred back to the local authority because no help had been provided. Inspectors also found that confused accountabilities often led to weak quality assurance and auditing of early help provision, alongside equally ineffective performance management and scrutiny.

50. Our survey ‘In the child’s time: professional responses to neglect’\(^{42}\) caused us to have a particular concern about the lack of effective services to deal with neglect. Inspectors found that there was often limited understanding locally about the prevalence and impact of neglect. This was hindering the strategic planning and commissioning of services to help families. When it came to assessing the needs of children and young people, local authorities were not analysing family histories sufficiently or understanding how children were being affected by the circumstances in which they were living. In a third of cases, this meant that children and young people were left for too long without protection from continued neglect. Inspectors also found that local authorities were struggling to engage parents who had their own difficulties. In some cases where early help was being provided to families, professionals were over-optimistic about parents’ ability to sustain changes. This, combined with a pattern of reduced resources, meant that ongoing support was rarely available.

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51. In strong authorities, we have found evidence of early help embedded into local support for families, with some services on offer that are making a tangible difference. Our evidence shows that some local authorities are increasingly making it a priority to work with their partners to put in place the help for families when concerns are raised. As a result, more children and young people were benefiting earlier from better focused and coordinated support.

52. Our inspectors also saw professionals making good use of standardised assessment tools to identify strengths, needs and risks in the families they were working with. Professionals were taking the time to establish the child's wishes and feelings, as well as trying to understand what life was like for them in their household. They did this either by talking to the child directly or, in the case of very young children, observing them closely.

53. In spite of the growing awareness and acceptance of the importance of providing help early to families, children and young people before they reach the statutory threshold for intervention, local authority spending on prevention has remained fairly static and, in the last year, reduced slightly. The ratio of £4 spent on reactive intervention for every £1 spent on prevention remains stubbornly stable. In their most recent research, the Association of Directors of Children's Services (ADCS) have found that (in 79% of the authorities participating) universal and early help services, such as children's centres and youth services, are moving to more targeted intervention or ceasing altogether largely due to funding pressures. Reactive intervention means that the major expense in the system lies in supporting those coming into and living in the public care system. These costs, while immediate, often extend into supporting those young people when they become adults.

Figure 7: Spending on prevention and intervention by local authorities (%)

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<tr>
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</thead>
<tbody>
<tr>
<td>Prevention</td>
<td>£1.26</td>
<td>£1.23</td>
<td>£1.23</td>
<td>£1.22</td>
</tr>
<tr>
<td>Intervention</td>
<td>£6.74</td>
<td>£7.77</td>
<td>£7.77</td>
<td>£7.78</td>
</tr>
</tbody>
</table>

The total spend on prevention and intervention has been calculated using the following definitions from the 2013–14 Section 251 outturn tables: i) prevention includes spending on: family support services and services for young people; ii) intervention includes spending on: children looked after, other children's and families services, safeguarding children and young people's services and youth justice.

Finance data for 2010–11 and 2011–12 are available from:

Finance data for 2012–13 and 2013–14 are available from:

The quality of assessments and planning

54. Our inspections give evidence that some leaders, managers and practitioners are prioritising the improvement of assessments in order to make effective decisions about how to protect children and young people and help families. However, basic practice and management oversight of this area of work needs to improve.

55. Some assessments are taking account of the views and experiences of children and their families and some families are also receiving help during the assessment period. The quality of plans made following assessments is, however, still not good enough. Plans often fail to articulate what needs to change to protect children and to reduce the need for further more coercive action. We will publish the results of our thematic inspection on assessment in spring 2015.
Child sexual exploitation

56. The reports by Professor Alexis Jay\textsuperscript{44} in 2014 into the sexual exploitation of children in Rotherham and Ann Coffey MP\textsuperscript{45} and the Children’s Commissioner\textsuperscript{46} identified widespread failure among services and professionals to recognise that some children and young people were at risk, or victims, of this form of abuse. Too often, children and young people who had been sexually exploited were wrongly labelled as ‘promiscuous’ or considered to have made a ‘lifestyle choice’ that entailed engaging in risky behaviour. Professor Jay’s report made clear that established services need to get better at listening to and helping children and young people who are at risk of sexual exploitation.

57. Ofsted’s inspection of local authority arrangements for the protection of children in Rotherham in 2012 was not good enough. The inspection framework used at the time was largely focused on intra-familial abuse and so was not sufficiently focused on child sexual exploitation. In common with others, Ofsted has learned lessons and is committed to continued internal challenge and improvement of how to inspect and judge professional responses to sexual exploitation of children and young people.

58. The single inspections that began in November 2013 carry more extended criteria to enable inspectors to evaluate the quality of professional interventions where children are at risk of, or are, being sexually exploited. This extends further into children missing from home, care or education.

59. Ofsted conducted an urgent thematic inspection in autumn 2014 on the sexual exploitation of children and young people. The report, ‘The sexual exploitation of children: it couldn’t happen here, could it?’, took account of evidence from single inspections, reviews of LSCBs, parallel inspections of children’s homes and the testimonies of more than 150 children and young people.\textsuperscript{47}


\textsuperscript{46} If it’s not better, it’s not the end – Inquiry into Child Sexual Exploitation in Gangs and Groups: One year on, Office of the Children’s Commissioner, 2015; www.childrenscommissioner.gov.uk/content/publications/content_920.

60. We found that, until recently, the tackling of sexual exploitation of children and young people had not been treated as a strategic priority by many local authorities. As a result, local arrangements to address the problem were often insufficiently developed and the leadership needed in this crucial area of practice was frequently lacking. In those authorities where child sexual exploitation had been given higher priority, the local strategy was better developed, with links to initiatives on issues such as gangs, licensing and the delivering of personal, health and social education in schools. Senior leaders and local politicians tended to have greater insight and understanding of this complex problem. However, LSCBs had, in too many instances, failed to challenge slow progress in developing sexual exploitation strategies and action plans. Partnership working was often disjointed and information was not being shared effectively between agencies to build a picture of child sexual exploitation in their local area.

61. On the frontline, our inspectors came across examples of excellent practice in dealing with this form of abuse. There was a wide range of initiatives aimed at increasing young people’s understanding of child sexual exploitation. Several local authorities were running powerful campaigns and some were developing targeted approaches to engaging young people perceived to be harder to reach and more vulnerable, for example those in care.

62. We are concerned about the extent to which the requirements of statutory guidance, issued by government in 2009, were not fully in place and being acted on. Of equal concern is the low priority given to this abuse by LSCBs. There was limited evidence of their obligations being fulfilled, both to oversee the effectiveness of what is done to protect children and to develop procedures that set out the roles and responsibilities of local agencies and professionals. Our other concerns raised by this thematic inspection were:

- the effectiveness of protective plans
- the management oversight of decisions
- the action taken when the risk of harm to a child or young person intensifies
- partner agencies not actively seeking or scrutinising management information about exploited children and young people, which consequently led to some local authorities having limited knowledge about the prevalence of child sexual exploitation in their area.

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63. Our report described the challenges faced by the system in applying child protection processes to the sexual exploitation of children and young people. The child protection system, and much of the guidance within it, is geared towards protecting children from abuse within the family environment. Where the abuse is being perpetrated outside the home, professionals need different approaches to protecting children that may be unfamiliar or not well resourced. We recommended in our report that this problem should be addressed through a revision to statutory guidance, which would make clear what protective action professionals should take in communities, residential and foster care, schools and other environments where children are at risk of, or suspected of, being sexually exploited.

**Missing children are at risk**

64. Children and young people who go missing are at increased risk of sexual exploitation and other forms of abuse. For this reason, Ofsted has become increasingly concerned about the lack of priority that agencies give to tracking children and young people who go missing, particularly those who are missing from education and residential or foster care. Since late 2013, we have asked local authorities to provide data about missing children and young people in their area as part of our inspection evidence. Many local authorities have not been able to provide that information. In addition, we found during the thematic inspection on child sexual exploitation that too many children and young people did not have a return interview following an episode of being missing. This meant that local authorities and police were missing opportunities to protect these children and young people effectively and gather intelligence to inform future work.

65. We have sharpened our guidance to inspectors on missing children and young people, both in relation to the inspections of local authorities and of individual providers. Incidents of children and young people missing from settings that Ofsted inspects are now required as evidence in all reports, along with a judgement on the effectiveness of action taken by those with a professional responsibility to look after and protect those children and young people.

66. At the start of all local authority inspections, a meeting is held jointly with police and local authority leads to discuss their records of children looked after who are missing and those who are missing from school. A follow-up meeting is held towards the end of the inspection to share the evidence from tracked cases against the action plans that were presented at the start of the inspection by the responsible local professional leads. All inspection reports will make clear reference to this evidence base and its weighting in the overall judgement. We urge local authorities, statutory partner agencies and LSCBs to prioritise the collation and oversight of robust management information and to take effective and concerted action where children and young people are missing from education, home or care.

67. Evidence from inspections shows that local authorities that are good at responding when children go missing typically have:

- shared, well understood arrangements for responding when children and young people go missing from home, school or care
- prompt and thorough return interview arrangements for all children and young people who go missing to listen and understand their reasons
- consultation with the young person about who they want to carry out the return interview
- robust monitoring of school attendance and arrangements to establish the whereabouts of children missing from education
- good record keeping and risk assessment that inform plans to reduce the risk of future missing episodes
- routine collation and analysis of return information and other local intelligence that is shared across agencies.

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Inspections of services to children looked after and achieving permanence

68. As part of our single inspections, we make a judgement about the services provided to all children looked after, with specific sub-judgements on adoption and care leavers. Separately, we inspect children’s homes, independent fostering agencies and voluntary adoption agencies.

69. A third of local authorities are providing good services for the children and young people in their care and for whom they have the responsibility to act as corporate parents. Of the 43 inspections of local authorities conducted since November 2013, four have been judged inadequate, 25 require improvement and 14 are good.

**Figure 8: Children looked after and achieving permanence judgement (%)**

<table>
<thead>
<tr>
<th>Inspections (43)</th>
<th>Outstanding</th>
<th>Good</th>
<th>Requires improvement</th>
<th>Inadequate</th>
</tr>
</thead>
<tbody>
<tr>
<td>33</td>
<td>58</td>
<td>9</td>
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</table>

70. In nearly a quarter of authorities, our inspectors observed that decisions about whether a child or young person should become looked after were not always being made quickly enough. However, once this decision was made, we saw that the length of time it takes to conduct care proceedings was reducing.
71. Too often, the services provided by local authorities are undermined by the lack of a coherent strategy for commissioning suitable placements. More than half of the local authorities we inspected were finding it difficult to comply with their duty of ‘sufficiency’.\(^{50}\) This is where they should secure a range of placements that meet the individual needs of children and young people. They found it particularly hard to place teenagers and children with complex needs. There was also an over-reliance on out-of-area placements and there was limited support for the children and young people. In a third of the authorities inspected, there was poor access to mental health services for all children and young people looked after.

72. More care is needed in many local authorities to secure the safety and welfare of children looked after. In these places, inspectors often found that responses to missing children were inadequate. For example, in some places, children were not spoken to after an episode of going missing and no decisive action was taken to keep them safe. Those authorities that require improvement will need to pay more attention to the quality of assessments, planning for children’s futures and the need for an independent reviewing officer’s oversight.

73. The most common reason for children and young people to cease being looked after is returning home to parents or relatives, although this decreased from 39% in 2010 to 34% in 2014. When children and young people return home, practice is too variable. In a third of the local authorities we inspected, assessments about what children and their families needed and the support they were given when a child returned home was not good enough. Returning home arrangements should help to keep them safe and avoid the need for them to become looked after again.

**Fostering agencies**

74. There were 51,315 children living in fostering placements at 31 March 2014. The majority of children were aged five to 15.\(^{51}\)

**Independent fostering agencies**

75. Over a third (118) of all independent fostering agencies were inspected between 1 April 2013 and 30 September 2014, with seven out of 10 being judged good or outstanding. These agencies were characterised by having:

- exceptional training and support for carers
- strong partnerships with commissioning local authorities
- well managed introductions for children and young people with new carers
- good assessments of foster carers.

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Inspections of children looked after and achieving permanence

76. One in 10 of these inspections, however, resulted in an inadequate judgement, where inspectors found a lack of priority afforded to the safety and welfare of children and young people, weak assessments of carers and poor consideration of the needs of children and carers when placements were made. The themes emerging from these inspection recommendations included:

- strengthening the fostering panel and decision making process
- improving the training opportunities offered to carers
- more rigorous management oversight of the services
- more frequent review of the quality of those services.

Adoption agencies

77. The number of children and young people being adopted continues to rise, from 3,782 in 2012–13 to 4,790 in 2013–14, an increase of 27%.52 Adoptive families are being matched to children and young people more quickly, with only 11% of families waiting more than nine months in 2013–14 compared with 16% in 2012–13. Of the 4,790 children and young people who were subject to a final adoption order in 2013–14, 4% (185) were aged 11 months or younger, 31% (1,475 children) were aged between 12 and 23 months, 47% (2,245 children) were aged between two and five years and 18% (895 children) were older than five.53

Figure 9: Children looked after and achieving permanence – adoption performance (%)

<table>
<thead>
<tr>
<th>Inspections (43)</th>
<th>Outstanding</th>
<th>Good</th>
<th>Requires improvement</th>
<th>Inadequate</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>40</td>
<td>47</td>
<td>7</td>
<td></td>
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Percentages do not add to 100 because of rounding.

78. Nearly half of local authorities have been judged good or outstanding for the adoption sub-judgement. Of the first 43 published reports, three local authorities were judged outstanding for adoption and 17 were judged to be good. Twenty require improvement and three were judged to be inadequate.

79. Those local authorities who were judged as outstanding for adoption were able to evidence a deep and service-wide commitment to achieving permanence for children and young people. Consistently high quality assessments, robust tracking of progress and prompt, yet realistic, work to match children with suitable adopters minimise delays for children at all stages of their journey. Innovative, individualised and, crucially, timely support brought lasting benefits to children, young people and families.

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Practice that requires improvement includes the variable quality of assessments in readying cases for court and explaining why adoption is in the child’s best interests, inconsistent management oversight and weak performance management of the case as it moves towards proceedings. Family finding in these places was also less effective and the use of parallel planning to reduce unnecessary delay was not embedded. Life story work in weaker authorities was not good enough.

In many places inspected, it remains a challenge to maintain a good supply of adopters and foster carers, despite some innovative recruitment activity. The imperative to continue trying, however, has never been greater. Professors Selwyn and Masson\(^{54}\) recently published research that showed that there is a significantly reduced risk of later disruption for children looked after who achieve legal permanence at a young age without delay and without having experienced multiple moves while being looked after. They found that most adoption breakdowns occurred in children’s teenage years. Their research evidence also identified that adoption was significantly more stable than special guardianship or placements made with the use of a residence order. They reaffirmed the priority that must be given to securing permanence for children promptly, supported by high quality, effective and decisive plans.

Voluntary adoption agencies

Twelve voluntary adoption agencies were inspected between 1 April 2013 and 30 September 2014, of which 11 were judged to be good or outstanding. These agencies were characterised by robust recruitment, preparation, assessment, approval and support of adopters. Good matching led to secure and stable families for children and young people and high quality direct work with families. Inspirational and ambitious leadership led to effective monitoring and management of the service. The most effective agencies demonstrated a commitment to continuous learning and child-centred practice and worked well with other agencies.

Children’s homes

In England, approximately 6,300 children (9% of all children looked after) were looked after in children’s homes as at 31 March 2014. Over three quarters of children in those homes were aged between 14 and 17.\(^{55}\) Many have experienced abuse, neglect and trauma, as well as disrupted and chaotic living, over many years of their young lives. Thirty-seven per cent live more than 20 miles from their families\(^{56}\) and three in 10 will have lived in at least five different places.\(^{57}\) Research has found\(^{58}\) that almost two in five had a statement of special educational needs, while three in five had clinically significant mental health difficulties and three quarters were reported to have been violent or aggressive in the past six months.


In spring 2014, Ofsted asked the children and young people living in children’s homes, their parents, their social workers, the children’s homes’ staff and other professionals for their views on their children’s home. Most of the children, parents and professionals who responded were positive about the care and support that children received from staff in children’s homes. Over 80% of children and young people said their care and support was good either most or all of the time: many said that the staff made the home a good place to live. Most children reported that they felt safe at the home all or most of the time. When asked about going missing, a large majority of children who responded said that they were welcomed back by the staff all or most of the time.

Since our last annual report, the performance profile of children’s homes has remained relatively stable. Although most homes are judged good or adequate, the proportion judged inadequate (between 2012–13 and 2013–14) has increased from 5% to 6% (from 108 to 130) and there has been a fall in the proportion of outstanding homes in the same period, from 16% to 12% (from 312 to 259).

**Figure 10: Inspection outcomes for all children’s homes inspected between 1 April 2013 – 31 March 2014 (%)**

<table>
<thead>
<tr>
<th>Category</th>
<th>2013 (%)</th>
<th>2014 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outstanding</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Good</td>
<td>64</td>
<td>61</td>
</tr>
<tr>
<td>Adequate</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Inadequate</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

Percentages do not add to 100 because of rounding.

A key issue for children’s homes is instability in the workforce and management of the homes. On 31 March 2014, 152 homes (7%) had no Registered Manager in place. We also found that just over a quarter of children’s homes had changed their Registered Manager during the year, with 69 homes experiencing three or more changes within that year. This will have created a great deal of instability for the children and young people living in the home and staff.
87. These homes care for some of our most vulnerable children and young people, who may have complex needs and therefore need to be cared for and supported by skilled and dedicated staff members. In January 2015, the Department for Education (DfE) published, for the first time ever, a census of managers and staff working in children’s homes.\textsuperscript{59} It found that:

- the average annual salary for managers was £23,172 and for non-managers was £15,841
- staff in private homes had poorer work benefits than staff working in local authority homes, with lower pay and longer working hours
- one in five members of staff and managers did not have the minimum qualification required for their role
- more than half of the managers had difficulties recruiting staff, with 91% reporting a lack of experience and 52% reporting a lack of qualifications among the applicants.

88. Ofsted has recently launched a new inspection framework for children’s homes. This is to support the new regulations that will be in place by April 2015 and that will introduce new quality standards for children’s homes. Under the new framework, we have replaced the judgement of ‘adequate’ with ‘requires improvement’. Inspectors will track the experiences of children and young people in order to evaluate the quality of practice, care and management and the difference this makes to their lives. While it is important to take into account children and young people’s starting points, this should not stop children’s homes from setting high ambitions for them. We want to see leaders, managers and staff teams who know the difference they are making to children and young people’s lives.

Services to young people leaving care

There were just over 9,000 care leavers aged 19 during 2013–14. Thirty two per cent were in education, 21% were in training or employment and 27% were not in either. Thirty four per cent of these young people were in independent living accommodation.

Figure 11: Children looked after and achieving permanence – experiences and progress of care leavers (%)

<table>
<thead>
<tr>
<th>Inspections (43)</th>
<th>Outstanding</th>
<th>Good</th>
<th>Requires improvement</th>
<th>Inadequate</th>
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<tbody>
<tr>
<td>35</td>
<td></td>
<td>51</td>
<td>14</td>
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</table>

In the single inspection, we make a judgement about the effectiveness of support and help for young people leaving the care of local authorities. So far, of the 43 inspections, we have judged 15 as good, 22 as requires improvement and six as inadequate.

Over two thirds of the authorities inspected are advising young people about their legal entitlements and the same number are providing a good range of safe and suitable accommodation. Inspections of these authorities reveal that there are good relationships with housing providers and that the quality of accommodation is regularly checked and considered by managers. Elsewhere, we have seen bed and breakfast accommodation used for some young people leaving care, which reflects a shortage of available emergency provision in a significant number of local areas.

The evidence from inspections presents a worrying situation for vulnerable young people starting out on their journeys as adults in some local authorities. These young people are leaving the care of local authorities with plans for their future support that they do not understand or that they say have limited relevance to their daily lives.

Several of the local authorities we inspected were unable to ensure us that care leavers were engaged successfully in education, employment or training. Inspectors found some good initiatives with colleges that increased opportunities for young people, but, in many authorities, plans were underdeveloped and lacked urgency.

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94. Cafcass is the independent voice for children and provides advice to the family court. In the last year it advised on more than 10,000 children where a local authority was seeking a care or supervision order that may result in them being removed from their family. Cafcass also advises the court in more than 46,000 private law applications where families need the court’s help to decide the best arrangements for who children live with or have contact with. In private law, Cafcass practitioners exercise an important safeguarding role.

95. Since the publication of our last annual report, we have introduced a new framework for inspecting Cafcass. Rather than inspecting separate regional areas, the new framework judges Cafcass as a single national organisation. The first inspection was conducted in early 2014 and the report was published in April 2014.

96. Over the past five years, Cafcass has improved significantly and is now judged to be good overall, with outstanding national leadership and governance.

97. Cafcass practitioners:
- consistently work well with families to help ensure that children and young people are safe and that the court makes decisions that are in children’s best interests
- provide a good service to parents when they need the courts to help them decide where their children or young people should live or who they should have contact with
- are good at identifying any risks to children and young people and write good quality letters to the court before the first court hearing
- help children and young people to express their views using a good range of tools
- make sure the court understands children and young people’s views
- quickly get to know the child and their family and give good quality advice to the court – helping to avoid delay in children’s lives.

98. The Cafcass Board has been effective in helping senior managers to focus on the right things and understand how they can do things better. Leaders and managers have created an environment that has supported improvement through:
- robust management oversight
- a shared understanding with staff about the organisational priorities
- a positive working environment, including low sickness levels
- good partnership relationships with judges, courts and the local authorities.
Workforce challenges in children’s social care

Social workers are managing high caseloads

99. Children’s social care services are now managing high caseloads at a time of significant staff vacancies. The impact of these pressures on the quality of professional practice is evident in our inspection reports and external research. According to the latest DfE figures, there are 24,890 (22,910 full-time equivalents) registered children’s social workers in England. In its annual investigation of the social care workforce, ‘Community Care’ revealed that the number of social work posts vacant in September 2014 stood at almost 10%, compared with 7% the previous year.

100. The ADCS reported in their latest ‘Safeguarding pressures’ research that approximately one third of the authorities participating are benefiting from new local investment in social work resource. However, for the other two thirds of authorities, there are recruitment and retention issues, including high staff turnover, difficulty recruiting experienced social workers, an associated increase in the use of agency staff and an increase in newly qualified social workers. The ADCS evidence corresponds with the findings of our local authority inspections and from what social workers have repeatedly told our inspectors. We have found common areas of weakness that include:

- the quality of frontline practice
- unmanageable caseloads
- little or no supervision
- managers not making decisions or helping social workers to manage risk
- managers and leaders who do not oversee practice consistently and do not insist on clear plans driven by authoritative professional help
- the quality of social work support for children looked after
- social workers who are unable to be clear with families about their concerns, about what has to change and the intervention that will be needed if the risk to the child or young person remains or intensifies.


62 ‘First increase in social work vacancies for four years see one in 10 posts vacant’, Community Care; November 2014; www.communitycare.co.uk/2014/11/14/first-increase-social-work-vacancies-four-years-sees-almost-one-10-posts-vacant/?cmpid=NLC|SCSC|SCDDB-2014-1114.

63 Safeguarding pressures – Research reports; Associate Directors of Children’s Services, November 2014; www.adcs.org.uk/news/safeguarding-pressures.html.
These workforce challenges are not new. There has been consistent strain on children’s social work services over a number of years. Reports from several sources have cited high caseloads year on year. A survey in 2013 indicated that social workers were being stretched to capacity, with nearly eight out of 10 reporting unmanageable caseloads as demand for services increases.

Figure 12: Consistent pressures on children’s social care services

2010: Community Care, Annual Workforce Surveys 2010, ‘One in six social workers have more than 40 cases’, Community Care, September 2010; www.communitycare.co.uk/2010/09/07/one-in-six-social-workers-have-more-than-40-cases/.


NQSWs is the abbreviation of ‘newly qualified social workers’.

64 The state of social work 2012; The British Association of Social Workers, 2012; www.basw.co.uk/resource/?id=500.

Workforce challenges in children’s social care

102. There is growing awareness of the conditions within which first class social work can thrive and flourish. Great social work demands high quality support, reasonable workloads and a professional culture that is challenging, testing and enhancing of professional confidence. The final report of the social work taskforce in 2009 made clear recommendations for reform of the social work profession. A key component of those reforms has been the establishment of a new professional ‘architecture’ to help drive high standards and to create a strong confident identity for social work. The role of Principal Social Worker has been established in most local authorities, two chief social workers are in post and The College of Social Work is fully embedded as a part of the professional landscape for social work. For probably the first time ever, social work has the professional leadership it needs to drive high standards and to complement the ambition of managers, local politicians and government.

103. Following Professor Munro's report, there is now broad consensus about the imperative of positioning social workers as professionals with explicit responsibilities and accountabilities. This requires them to take greater responsibility for practice standards. It also requires managers to advise and oversee with demanding rigour, monitoring performance against that in adjacent and similar local authorities. Employers now have to pay much more than lip service to the value of continuous professional development in the way that it is enshrined and resourced in other professions such as medicine and nursing.

104. A review commissioned by the DfE in 2014 about the education of children’s social workers, by Sir Martin Narey, recorded concerns about the raw calibre of many undergraduates (only 31% having one or more A level passes since 2003, according to the General Social Care Council) and significant deficiencies in the training of child and family social workers. The review also identified insufficiently rigorous audit of the standards of teaching and placement experience. As a consequence, too many employers reported new graduates being insufficiently prepared for child protection work and as such not fit for employment, despite frequent and serious staff shortages.

105. The first of Narey’s recommendations has been met in the publication by the Chief Social Worker for children of a ‘Knowledge and skills statement,’ which concisely summarises the things a new social worker must know and be able to do at graduation. Further work is being taking forward to encourage training partnerships between higher education institutions and employers. This will enhance the role of employers in social worker training, for example involving them in student selection, in shaping and supporting the content of teaching and in designating the numbers of placements. The government is also reviewing how best to improve the processes for endorsing and approving all social work initial training. Specific aspects of the Frontline programme (which started training with its first cohort in 2014), such as 200 days in placement, direct graded observations of practice and a focus on leadership potential, are good examples of the sorts of training reforms that have started to happen and that should lead to improved practice. ‘Step up to social work’ is also an innovative tailored employer-led work place training programme that provides successful trainees with a qualification in social work alongside hands-on experience.
The importance of strong and consistent leadership

106. Our inspection evidence from local authorities, regulated services and thematic inspections provides strong messages about the importance of leadership in stabilising and inspiring the workforce. Last year, Ofsted committed to look at the leadership of children’s social care services in local authorities in more depth. In July 2014, we undertook a thematic inspection to identify good practice and we are publishing our findings alongside this annual report. The local authorities we inspected as part of this work were selected either because they had previously been judged as having good or outstanding leadership or because they had improved from an earlier judgement of inadequate. The management structures of these authorities varied depending on their size, geography and history.

In the stronger local authorities our inspectors found that:

- the local authorities had an open, honest and collaborative approach to their work
- there was clarity of responsibility and accountability for chief executives, directors, lead members and leaders of councils
- directors had a clear line of sight to the frontline, which was enhanced by data and feedback, and had strong relationships with staff and partners
- directors used creative ways of quality assuring practice, managing complex cases and responding to calls for improvement
- the knowledge base, relationship skills and expectations of the directors of children’s services were critical in either improving or sustaining the performance of people and services
- local authority leaders took decisive action when necessary, set clear and high expectations for staff and inspired them to perform well.

107. In the authorities that had improved from inadequate:

- supervision was regular and constructive
- leaders were motivational and gave regular input about improving performance
- there was an open culture where feedback from staff and managers was welcomed and acted on
- critically, leaders of children’s services were paying attention to workloads, performance information and protecting budgets.
108. The results from our current local authority inspections show that nearly a third have been judged to have good or better leadership, management and governance within their local authority. Hampshire was judged to be outstanding.

**Figure 13: Leadership, management and governance judgement (%)**

| Inspections (43) | 2 | 28 | 53 | 16 |

Percentages do not add to 100 because of rounding.

109. Maintaining consistent leadership in children’s services is, however, a continual challenge. Over the last seven years, turnover among directors of children’s services has increased from 19% to 27%. In 2013–14, this has meant that a third of local authorities (33%) had at least one change of director of children’s services during the year. Many attribute the high turnover of leaders in the system to Ofsted and the process of inspection. Although our analysis of the evidence, illustrated in Figure 14, does not support this claim, we do understand that directors of children’s services are held accountable for the quality of services they deliver and that this can be a heavy burden in a system that is under pressure.

**Figure 14: Change of director of children’s services after an Ofsted inspection, by overall effectiveness (%)**

<table>
<thead>
<tr>
<th>Overall Effectiveness</th>
<th>0–3 months</th>
<th>3–6 months</th>
<th>No change or changed after 6 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outstanding (52 inspections)</td>
<td>15</td>
<td>4</td>
<td>81</td>
</tr>
<tr>
<td>Good (70 inspections)</td>
<td>4</td>
<td>9</td>
<td>87</td>
</tr>
<tr>
<td>Adequate/requires improvement (124 inspections)</td>
<td>7</td>
<td>7</td>
<td>85</td>
</tr>
</tbody>
</table>

Percentages do not add to 100 because of rounding.

Local authorities judged to be outstanding have not been included as the sample size is too small. Period covers the start of the safeguarding and looked after children inspections in 2009 (taking the lower of the two overall effectiveness judgements) to the single inspection framework as at September 2014. Director of children’s services information provided by the Association of Directors of Children’s Services.
110. Our inspection evidence this year has confirmed that the system to help, care for and protect children and their families is geared towards reactive practice and policy. Local authorities are, out of necessity, incurring high costs and devoting specialist professional expertise to managing crises in families or taking children and young people into care, rather than providing early help, which might help families to stay together.

111. Children and young people who are at risk of harm need more help when difficulties first arise, throughout their time in care and as they move into adulthood. When children go missing from home, from care or from education, they are disproportionately at risk of sexual exploitation and other forms of abuse. There needs to be more focus on talking to these children and young people after each episode of going missing, to listen to their worries and understand what is driving them away. That is why our inspections now report on arrangements for return interviews with children and young people who have gone missing. Our new inspection framework for children’s homes expects good homes to challenge local authorities that do not meet the requirement in statutory guidance to offer return home interviews.

112. In the year ahead, we will continue to inspect and regulate with the best interests of children and families in mind. We also intend to start consulting with government and local authorities about new models for inspection. The inspection framework for children’s homes will be implemented from April 2015 to accommodate the government’s ambitious new regulations and quality standards.

113. We know it is critical that services work together to protect children and that there are issues that would benefit from a shared view from two or more of the inspectorates. We are therefore launching a programme of targeted area inspections that will be conducted jointly. We have committed to completing six of these joint inspections before March 2016. These targeted inspections will evaluate how local agencies work together to protect children, focused on specific areas of concern such as the sexual exploitation of children and young people.

114. Within Ofsted, we will continue to focus attention on the consistency of inspection and the quality of our reports, bringing in stronger regionalisation of our social care functions. We will continue to be a strong voice in shared debates about what inspection must and should address and how it can be helpfully deployed to improve services to vulnerable children and their families.

69 These are the Care Quality Commission, HMI Constabulary and HMI Probation.
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