Public Document Pack

Health Overview and Scrutiny Panel

Thursday, 25th September, 2014
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

Councillor Stevens (Chair)
Councillor Claisse
Councillor Bogle
Councillor Mintoff
Councillor Parnell
Councillor Spicer
Councillor White

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PUBLIC INFORMATION

Role of Health Overview Scrutiny Panel (Terms of Reference)

The Health Overview and Scrutiny Panel will have 6 scheduled meetings per year with additional meetings organised as required.

- To discharge all responsibilities of the Council for health overview and scrutiny, whether as a statutory duty or through the exercise of a power, including subject to formal guidance being issued from the Department of health, the referral of issues to the Secretary of State.
- To undertake the scrutiny of Social Care issues in the City unless they are forward plan items. In such circumstances members of the halth Overview and Scrutiny Panel will be invited to the relevant Overview and Scrutiny Management Committee meeting where they are discussed.
- To develop and agree the annual health and social care scrutiny work programme.
- To scrutinise the development and implementation of the Joint Strategic Needs Assessment and Health and Wellbeing Strategy developed by the Health and Wellbeing Board.
- To respond to proposals and consultations from NHS bodies in respect of substantial variations in service provision and any other major health consultation exercises.
- Liaise with the Southampton LINk and its successor body "Healthwatch" and to respond to any matters brought to the attention of overview and scrutiny by the Southampton LINk and its successor body "Healthwatch"
- Provide a vehicle for the City Council's Overview & Scrutiny Management Committee to refer recommendations arising from panel enquiries relating to the City's health, care and well-being to Southampton's LINk and its successor body "Healthwatch" for further monitoring.
- To consider Councillor Calls for Action for health and social care matters.
- To provide the membership of any joint committee established to respond to formal consultations by an NHS body on an issue which impacts the residents of more than one overview and scrutiny committee area.

Public Representations

At the discretion of the Chair, members of the public may address the meeting about any report on the agenda for the meeting in which they have a relevant interest

Smoking policy – the Council operates a no-smoking policy in all civic buildings.

Mobile Telephones:- Please switch your mobile telephones to silent whilst in the meeting.

Use of Social Media:- If, in the Chair's opinion, a person filming or recording a meeting or taking photographs is interrupting proceedings or causing a disturbance, under the Council's Standing Orders the person can be ordered to stop their activity, or to leave the meeting

COUNCIL'S PRIORITIES:

- Jobs for local people
- Prevention and early intervention
- Protecting vulnerable people
- Affordable housing
- Services for all
- City pride
- A sustainable Council

CONDUCT OF MEETING

The general role and terms of reference for the Overview and Scrutiny Management Committee, together with those for all Scrutiny Panels, are set out in Part 2 (Article 6) of the Council's Constitution, and their particular roles are set out in Part 4 (Overview and Scrutiny Procedure Rules of the Constitution.

Business to be discussed
Only those items listed on the attached agenda may be considered at this meeting.

Rules of Procedure
The meeting is governed by the Council Procedure Rules as set out in Part 4 of the Constitution.

Quorum
The minimum number of appointed Members required to be in attendance to hold the meeting is 3.

DISCLOSURE OF INTERESTS

Members are required to disclose, in accordance with the Members' Code of Conduct, ***both*** the existence ***and*** nature of any "Disclosable Pecuniary Interest" or "Other Interest" they may have in relation to matters for consideration on this Agenda.

DISCLOSABLE PECUNIARY INTERESTS

A Member must regard himself or herself as having a Disclosable Pecuniary Interest in any matter that they or their spouse, partner, a person they are living with as husband or wife, or a person with whom they are living as if they were a civil partner in relation to:

(i) Any employment, office, trade, profession or vocation carried on for profit or gain.
(ii) Sponsorship:
Any payment or provision of any other financial benefit (other than from Southampton City Council) made or provided within the relevant period in respect of any expense incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.
(iii) Any contract which is made between you / your spouse etc (or a body in which the you / your spouse etc has a beneficial interest) and Southampton City Council under which goods or services are to be provided or works are to be executed, and which has not been fully discharged.
(iv) Any beneficial interest in land which is within the area of Southampton.
(v) Any license (held alone or jointly with others) to occupy land in the area of Southampton for a month or longer.
(vi) Any tenancy where (to your knowledge) the landlord is Southampton City Council and the tenant is a body in which you / your spouse etc has a beneficial interests.
(vii) Any beneficial interest in securities of a body where that body (to your knowledge) has a place of business or land in the area of Southampton, and either:

a) the total nominal value for the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or
b) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you / your spouse etc has a beneficial interest that exceeds one hundredth of the total issued share capital of that class.

Other Interests

A Member must regard himself or herself as having an, 'Other Interest' in any membership of, or occupation of a position of general control or management in:

Any body to which they have been appointed or nominated by Southampton City Council

Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

Any body whose principal purpose includes the influence of public opinion or policy

Principles of Decision Making

All decisions of the Council will be made in accordance with the following principles:-

- proportionality (i.e. the action must be proportionate to the desired outcome);
- due consultation and the taking of professional advice from officers;
- respect for human rights;
- a presumption in favour of openness, accountability and transparency;
- setting out what options have been considered;
- setting out reasons for the decision; and
- clarity of aims and desired outcomes.

In exercising discretion, the decision maker must:

- understand the law that regulates the decision making power and gives effect to it. The decision-maker must direct itself properly in law;
- take into account all relevant matters (those matters which the law requires the authority as a matter of legal obligation to take into account);
- leave out of account irrelevant considerations;
- act for a proper purpose, exercising its powers for the public good;
- not reach a decision which no authority acting reasonably could reach, (also known as the "rationality" or "taking leave of your senses" principle);
- comply with the rule that local government finance is to be conducted on an annual basis. Save to the extent authorised by Parliament, 'live now, pay later' and forward funding are unlawful; and
- act with procedural propriety in accordance with the rules of fairness.

Dates of Meetings: Municipal Year 2014/2015

2014	2015
24 July	29 January
25 September	26 November
27 November	

AGENDA

Agendas and papers are now available via the City Council's website

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

To note any changes in membership of the Panel made in accordance with Council Procedure Rule 4.3.

2 APPOINTMENT OF VICE-CHAIR

Appoint a Vice Chair for the Municipal Year 2014/15.

3 DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

In accordance with the Localism Act 2011, and the Council's Code of Conduct, Members to disclose any personal or pecuniary interests in any matter included on the agenda for this meeting.

NOTE: Members are reminded that, where applicable, they must complete the appropriate form recording details of any such interests and hand it to the Democratic Support Officer.

4 DECLARATIONS OF SCRUTINY INTEREST

Members are invited to declare any prior participation in any decision taken by a Committee, Sub-Committee, or Panel of the Council on the agenda and being scrutinised at this meeting.

5 DECLARATION OF PARTY POLITICAL WHIP

Members are invited to declare the application of any party political whip on any matter on the agenda and being scrutinised at this meeting.

6 STATEMENT FROM THE CHAIR

7 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the minutes of the meeting held on 24th July 2014 and to deal with any matters arising, attached.

8 THE IMPACT OF HOMELESSNESS ON THE HEALTH OF SINGLE PEOPLE

Report of the Assistant Chief Executive seeking approval for the Panel's draft inquiry report The Impact of Housing and Homelessness on the Health of Single People, attached.

9 UNIVERSITY HOSPITAL SOUTHAMPTON; EMERGENCY DEPARTMENT REPORT

Report of the Chief Executive of University Hospitals Southampton detailing the Hospital's Emergency Department performance and preparation for inspection, attached.

10 ADULT SOCIAL CARE TRANSFORMATION

Report of the Cabinet Member for Health and Adult Social Care and the Director, People providing an update on the transformation of the People Directorate, attached.

11 BETTER CARE SOUTHAMPTON UPDATE

Report of the Cabinet Member for Health and Adult Social Care providing an update on the Better Care fund, attached.

12 OFSTED ACTION PLAN

Report of the Director, People detailing the outcomes and action plan of the inspection into children's safeguarding, attached.

Wednesday, 17 September 2014 HEAD OF LEGAL AND DEMOCRATIC SERVICES

SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 24 JULY 2014

Present: Councillors Stevens (Chair), Claisse, Bogle and Mintoff

Apologies: Councillors Parnell, Spicer and White

1. **APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)**
The Panel noted the apologies of Councillors Parnell, Spicer and White.

2. **APPOINTMENT OF A VICE-CHAIR**
The Panel deferred the appointment of vice-chair of the Panel to a future meeting.

3. **DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS**
The Panel noted that Councillor Bogle was an appointed representative of the Council as a Governor of the University Hospital Southampton NHS foundation Trust.

4. **MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)**
RESOLVED: that the minutes for the Panel meeting on 15 May 2014 be approved and signed as a correct record.

5. **LOCAL SAFEGUARDING CHILDREN BOARD: DRAFT ANNUAL REPORT 2013/2014**
The Panel noted the report of the Independent Chair of the Local Safeguarding Children's Board detailing the Board's Draft Annual report.

With the permission of the Chair, Mr Joe Hannigan from the Fairness Commission, addressed the meeting.

The Panel discussed the relevance of the comparator set used within the report seeking to understand why the report indicated that the City's performance was different from its geographical neighbours. It was noted that the City did compare favourably to areas that shared the City's economic and demographic circumstance. The Panel noted that there was not one unique factor that could be singled out as the identifier for the City's performance.

It was explained that the Board had undergone significant change over the course of the municipal year including the appointment of a new Chair and a review of the membership. The Panel was assured that attendance at meetings was extremely good and that there was significant challenge to the reports presented to Board members.

6. **SOUTHAMPTON SAFEGUARDING ADULTS BOARD: ANNUAL REPORT 2013-14**
The Panel considered the report of the Independent Chair of the Southampton Safeguarding Adults Board detailing the annual report.

The Panel noted that the Board had undergone changes over the course of the year including the appointment of a new Chair of the Board. The Panel noted that the principal aim of the Board is to promote the wellbeing and protect 'adults at risk' of harm in its area.

The Board's Independent Chair detailed how the City had performed against the Key Performance Indicators set for 2013-2014. The Panel were informed that the Southampton Safeguarding Adults Board (SSAB) will conduct audits to better understand why the conversion rate, for alert to referral rates, is lower than national comparator and explained that the Board would want to show an increase in the conversion rate by 2014-15.

The Panel were briefed on how the City had performed against targets to tackle abuse in the City, whether it be financial abuse, physical abuse or through neglect. It was explained to the Panel the Importance for the SSAB to understand why abuse within residential care has decreased and share locally and nationally examples of good practice. The meeting was informed that the SSAB measured its success against data and learned that the Board employ a number of different and innovative methods to collect as much data as possible to drive evidenced based improvement in safeguarding practice.

RESOLVED

(i) to encourage a better understanding amongst Councillors of Adult Safeguarding matters; and
(ii) that the Southampton Safeguarding Adults Board's strategic action plan be brought to the Panel at an appropriate meeting in 2015.

7. **ADULT SOCIAL CARE LOCAL ACCOUNT FOR 2013/14**

The Panel noted the report of the Director, People detailing key performance information concerning the previous financial year along with important strategic and policy developments.

It was noted that there were delays in producing the Account for 2012/13 which has resulted in some similarities with the 2013/14 report.

The Panel acknowledged that there was cross party support for transforming the service and sought to understand the reasoning for the delays. It was explained that there had been some resistance to the potential changes by clients and employees, partly because of the high quality of services currently provided.

8. **QUALITY EXCEPTION REPORT - FOCUS ON RESIDENTIAL AND DOMICILIARY CARE**

The Panel considered the report of the Director of Quality and Integration detailing an overview, by exception, of key quality of care issues for the main health and care provider organisations, including nursing homes in Southampton.

Mr Joe Hannigan from the Fairness Commission, was present and with the consent of the Chair addressed the meeting.

The Panel noted the drive to ensure quality within the health system set out in the report including;

- the steps taken to tackle the high number of blood infections caused by MRSA at the University Hospital Southampton outlined within the report and detailed at the meeting;
- steps to eradicate mixed sex accommodation;
- the Care Quality Commission's new methodology for undertaking reviews; and
- that Southern Health NHS Foundation Trust were continuing to make progress against compliance issues identified at Antelope House.

The report detailed the slow improvement in the quality of care provided by nursing homes within Southampton. The Panel discussed how the Council had reacted to the 5 homes suspended from placement in the winter of 2013. It was noted that the role of the Integrated Commissioning Unit was to advise and suggest actions that would result in improvement rather than to take control of the homes. The Panel noted that the potentially frail nature of some residents often meant that it was not practical to decant residents from their homes if it failed to meet required standards.

The meeting explored the quality of advice available for individuals regarding accessing the correct benefits and allowances and raised concerns that whistle blowers would not be adequately protected and may become blacklisted from alternative employment. It was explained that the Council was undertaking a tender process for Domiciliary Care Provision and that staffing matters, and compliance with standards, would form an important part of the tender process.

RESOLVED that

(i) the Panel notes the areas of quality concern and the actions in place,
(ii) the Panel supports the assurance processes outlined for the monitoring of the Domiciliary Care contract

9. **UNIVERSITY HOSPITAL SOUTHAMPTON; EMERGENCY DEPARTMENT REPORT**

The Panel considered the report of the Chief Executive for University Hospital Southampton NHS Foundation Trust providing the Panel with an overview of last year's performance and latest position against the Emergency Department accident and emergency targets.

The Panel noted that the Hospital's performance against the target set for the emergency department had continued to be erratic. It was noted that the Hospital continued to have difficulties discharging patients that required care packages and assessments. It was explained that without an adequate flow of patients through the system then it became difficult to process patients and meet performance targets. The Trust's Chief Executive stated that this had not affected the Hospitals ability to deal with major trauma incidents and that customer satisfaction of the department was generally very high.

It was explained at the meeting that it was hoped that new working practices would help to alleviate the current problems relating to discharging patients. It was noted that the Hospital proposed to introduce a system of:

- Trusted Assessment that would allow specially trained hospital staff to assess the needs of patients prior to discharge without the requirement to have a social services staff member present; and
- Discharge to Assess – which would enable a full assessment of a patients needs outside of the emergency department and therefore free beds up.

RESOLVED that, should the current measures not improve the Hospital's performance against the accident and emergency waiting targets, the Panel would call a meeting and invite all the stakeholders to consider what actions need to be taken to improve the Hospital's performance.

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		THE IMPACT OF HOMELESSNESS ON THE HEALTH OF SINGLE PEOPLE		
DATE OF DECISION:		25 SEPTEMBER 2014		
REPORT OF:		ASSISTANT CHIEF EXECUTIVE		
CONTACT DETAILS				
AUTHOR:	**Name:**	Dorota Goble	**Tel:**	023 8083 3317
	E-mail:	Dorota.goble@southampton.gov.uk		
Director	**Name:**	Suki Sitaram, Assistant Chief Executive	**Tel:**	023 8083 2060
	E-mail:	Suki.sitaram@southampton.gov.uk		

STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY

The Health Overview and Scrutiny Panel undertook an Inquiry into the Impact of Homelessness on the Health of Single People between February and July 2014. During this time the Panel heard from a wide range of witnesses and visited a number of the homeless housing services. The issues identified and recommendations of the Panel are presented in the draft report attached in Appendix 1.

RECOMMENDATIONS:

(i) That the Panel considers the draft report and agrees the recommendations for submission to Cabinet in October.

REASONS FOR REPORT RECOMMENDATIONS

1. As part of the HOSP's terms of reference the panel has a role to undertake inquiries and report their recommendations to Cabinet.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None

DETAIL (Including consultation carried out)

3. The Impact of Homelessness on the Health of Single People Inquiry Terms of Reference and Inquiry Plan were agreed by the Health Overview and Scrutiny Panel on undertaken 23 January 2014. The terms of reference and Inquiry Plan are attached as Appendix 1 & 2.

4. The Panel undertook the inquiry over 5 evidence gathering meetings from February to May 2014. During this time the panel heard from a wide range of witnesses as well visiting a number of housing providers to speak first hand to staff, residents and service users The Panel's draft findings and recommendations are attached as Appendix 3

5. The report has been sent out to all the witnesses to give feedback and any suggested amendments or comments received will be reported to the Panel verbally at the meeting.

6. The Panel are asked to consider the draft report and recommendations on the Impact of Homelessness on the Health of Single People for submission to Cabinet on 21st October 2014.

RESOURCE IMPLICATIONS

Capital/Revenue

7. None

Property/Other

8. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

9 The powers and duties of health scrutiny are set out in the Local Government and Public Involvement in Health Act 2003.

Other Legal Implications:

10. None

POLICY FRAMEWORK IMPLICATIONS

11. None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	ALL

SUPPORTING DOCUMENTATION

Appendices

1.	Inquiry Terms of Reference and Inquiry Plan
2.	Draft report for the Impact of Homelessness on the Health of Single People

Documents In Members' Rooms

	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
	None	

THE IMPACT OF HOUSING AND HOMELESSNESS ON THE HEALTH OF SINGLE PEOPLE INQUIRY TERMS OF REFERENCE AND PROGRAMME

1. Scrutiny Panel:
Health Overview and Scrutiny Panel

2. Membership:
a. Councillor Matthew Stevens (Chair)
b. Councillor Matthew Claisse
c. Councillor Carol Cunio
d. Councillor Georgina Laming
e. Councillor Brian Parnell
f. Councillor Sally Spicer

3. Purpose:
To consider the impact of housing and homelessness on the health of single people, a significant number of whom have complex needs, live unsettled and transient lifestyles, and to examine the difficulties that their everyday life presents to deliver a preventative and planned approach to improve their health and well being and access to a settled and decent home.

4. Background:

4.1 This Inquiry will focus on the health of homeless single people. The definition of homelessness for this inquiry will be those who are sleeping rough, living in insecure accommodation such as a squat or sofa-surfing, in short-term accommodation such as a hostel or recently moved into to private rented accommodation for the first time after a period of homelessness. It will also examine the quality and impact of accommodation that homeless people move on to, which is likely to be either a shared home or a single unit.

4.2 The rationale to focus on single homeless people stems from the high demand for single person's accommodation, with over half of the 15,000 people on the housing register are in need of single units. Evidence suggests that a high proportion of homeless individuals having complex health needs, requiring significant and intensive support from specialist services. The Southampton experience, through the 2013 Homelessness Strategy Review identified homeless single people are:

- More likely to be marginalised or isolated, with limited support networks
- Less likely to be in priority need for the council to house them but likely to have aggregate needs that will make their life more chaotic
- Experience barriers to accessing mainstream primary care
- More likely to have no recourse to public funds
- Significantly affected by the Welfare Reforms, particularly changes to the local housing allowance, migrant benefits rights and Universal Credit

4.3 Homeless families and older people over 65 are much more likely to be accepted as homeless due to a priority need and are the key focus for other current initiatives such as the Families Matter and the Better Care (Integrated Transformation Fund) programmes. Therefore these groups will not be included as part of this Inquiry.

4.4 The model for homelessness prevention in Southampton is delivered and commissioned by a wide range of public and third sector providers and has a strong history of collaboration and good practice through the Homeless Prevention Strategy. Despite preventing a large number of single households from becoming homeless in 2012/13 there were still 520 people on the Homeless Health Team's register. However, increasing trends of homelessness are adding pressures on services for homeless people.

4.5 The national picture of funding these services is also changing with financial pressures in the public sector. Nationally, the ring-fence for Supporting People grants has been removed and across the country councils are reducing spend on Supporting People services. Additional budget pressures also prevalent in the public and third sector are placing further pressures on the services that support homeless people.

4.6 There is much evidence published that homelessness and poor quality housing can have a significant and negative impact on an individual's health and well being. Those who are who have slept rough have significantly higher levels of premature mortality. Homeless Link undertook a national audit of over 700 homeless people which demonstrated the inequality in the health needs of homeless people:

- **Mental Health** – 7 out of 10 homeless people have one or more mental health needs, although they may not be diagnosed, it is estimated that 30% of the general population experience some form of mental distress; over a third of homeless clients said they would like more support. It is estimated mental health costs £9.7 million in Southampton, with £1.3 million worth of anti-depressants prescribed in 2011/12.
- **Substance misuse** – Over half of clients in the audit use one or more types of illegal drug, with around a quarter engaged is some for of treatment or support. 3 out of 4 clients consume alcohol regularly, with 1 in 5 drinking harmful levels. Alcohol misuse in hospital admissions and primary care treatment is estimated to cost £12 million per annum in Southampton.
- **Physical health** – 8 out of 10 homeless people had one or more physical health needs including:

Condition	Homeless People	General Population
Musculoskeletal problems	38%	10%
Respiratory problems	32%	5%
Eye complaints	25%	1%

- **Tuberculosis** – TB rates have doubled in the UK in the last 10 years. The homeless population is particularly vulnerable to the disease, and more likely to present with advanced forms. However, even if diagnosed and being treated a homeless patient is also more likely to discontinue treatment given their chaotic lifestyle.

4.7 Primary care is the first point of contact for health services to respond to an individuals health needs. However, evidence in the national audit suggests that homeless people are more likely to access healthcare through accident and emergency services, with their stay likely to be longer. Their lifestyles may also mean that they are more likely to seek medical help when their condition has significantly deteriorated. The review will examine the picture of homelessness access to health care service in the city.

4.8 Historically, single homeless people have predominantly been males over 30, anecdotally these are often people who have had traumatic or troubled life experiences including service men, care leavers and offenders; however, in recent years the trend has changed to reflect a larger proportion of women with the age profile getting younger. The interventions to support homeless people are generally split into those for young people, aged 16-25 and adults.

4.9 The pathway from rough sleeping to settled and suitable accommodation can be a long one and requires intensive support to help an individual to move on. It is estimated that it takes 7 attempts for an individual to make a real difference to their lives through intervention, equating to approximately 2 years for individuals with intensive support to turn things around. The panel will need to recognise the long term support needed to make a difference to these individuals and will examine the challenges and opportunities for the current homelessness support and health services delivery.

5. Objectives:

a. To understand the current model for homelessness prevention supports and how it promotes better health outcomes for single people
b. To recognise what works well and what needs to improve locally, learning from best practice nationally.
c. To identify if there are any gaps or blockages in homeless prevention and health interventions for single homeless people
d. To explore how the Houses in Multiple Occupation (HMO) Licensing scheme contributes to the health and wellbeing of tenants who have been homeless, or at risk of homelessness, and what opportunities there are to provide further support by working in partnership with others.
e. To explore the adequacy of single accommodation and the effectiveness of the support pathway that leads to settled accommodation for those who have been homeless, inline with any existing contract periods.
f. To consider further collaboration or invest to save opportunities that would prevent future increasing demand or reduce homelessness in the city, within existing budget constraints.

6. Methodology:

a. Outline of current national policy and local activity including:
   - The service model for homelessness prevention and Supporting People
   - National and local data on health inequalities for single homelessness
b. Engage commissioners, public sector and third sector providers
c. Visit facilities to understand service provision and talk face to face with clients and frontline staff
d. Understand client needs through direct contact with service users alongside case studies
e. National and local health audit results and key data for Southampton
f. Identify and consider best practice and options for future delivery:
   - National best practice examples
   - Local success stories

7. Proposed Timetable:

Five meetings February 2014 – May 2014

INQUIRY PROGRAMME

Meeting 1: 20 February 2014
SETTING THE SCENE
National and local picture of homelessness
Single homelessness health needs and trends
Consider the health inequalities of homelessness compared to the local population and cost /impacts of demand on services
Outline of the model for homelessness prevention for adults and young people

To be invited:
Sarah Gorton, Homeless Link
Andrew Mortimore, Director of Public Health
Liz Slater, Housing Needs Manager
Matthew Waters, Commissioner for Supporting People and Adult Care Services
TBC, Young people perspective
Stephanie Ramsey, Integrated Commissioning Unit
Pam Campbell, Homelessness Health team*
Alison Elliott, People Director
Cllr Payne, Cabinet Member for Housing and Sustainability
Cllr Shields, Cabinet Member for Health and Adult Social Care

Visits to be arranged prior to meeting*
Homeless Health Team
Street Homeless Prevention Team

Meeting 2: 20 March 2014
PART A: ACCESS TO SERVICES
To be invited:
Homelessness Prevention, Liz Slater
Homeless Health team, Pam Campbell
Substance Misuse Services, Colin McAlister
Mental Health services – Southern Health TBC
Accommodation overview – Two Saints / Matthew Waters, Supporting People
Primary care – access and experiences of GPs
Acute Care – admission to hospital, support whilst in hospital and discharge from hospital
Probation / YOT
Adult Safeguarding, John Callaway, Southampton Social Services

PART B: SERVICE PROVIDERS
Adults:
Society of St James*
Two Saints*
Floating support to keep people in their own services
MIND – Richmond Fellowship*

Young People
YMCA
Chapter 1*
No Limits*

Visits to be arranged prior to meeting*
Two Saints, Patrick House, Breathing Space, No Limits, MIND – Richmond Fellowship
GP Forum 12th March
Good practice examples – to be advised

Meeting 3: 2nd April 2014
MOVING ON TO LONG TERM ACCOMMODATION IN THE PRIVATE SECTOR
To examine the quality and availability of accommodation in the private sector

To be invited:
Regulatory Services – licensing and quality of private rented accommodation
Landlord's perspective
Housing strategy and 'Right to Buy' receipts – opportunity for single unit accommodation – Sherree Stanley

Meeting 4: 17th April 2014
MOVING ON: LIFE SKILLS AND ADVICE
Helping individuals to develop the skills and the confidence to stay in settled and safe accommodation

To be invited:
Housing Needs Manager
Booth Centre*
EU Welcome / border control
No Limits
Society of St James
Two Saints
YMCA*
Chapter 1

Visits to be arranged prior to meeting*

Meeting 5: 15th May 2014
INQUIRY RECOMMENDATIONS
Overview of the evidence and emerging recommendations

Public Health
Housing Needs Manager
Supporting People Commissioner
CCG / ICU
Healthwatch

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Health Overview and Scrutiny Panel

THE IMPACT OF HOUSING AND HOMELESSNESS ON THE HEALTH OF SINGLE PEOPLE

PANEL MEMBERSHIP

Councillor Stevens (Chair)
Councillor Matthew Claisse
Councillor Sarah Bogle
Councillor Sharon Mintoff
Councillor Brian Parnell
Councillor Sally Spicer
Councillor Ivan White

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Contents **Page**

The Impact of Housing and Homelessness on the Health of Single People

INTRODUCTION

1. The model for homelessness prevention in Southampton has significantly reduced homelessness in the City over the last decade, reducing homeless applications and acceptances from the 1000s to around 200 in 2012/13. However, homelessness remains in the system with 520 people still on the Homeless Healthcare Team's register. Welfare Reforms and a heavy reliance on private sector rented properties, of which a high proportion is unaffordable to those on or below the average wage in the City, are making the cycle difficult to break for entrenched individuals with chaotic lives and complex needs. The way services are funded is also changing adding increasing pressures on these vital preventative public services.

2. Homelessness for the purpose of this inquiry is where an individual finds themselves sleeping rough, living in insecure or short-term accommodation or at risk of being evicted from their home.

3. The purpose of the Inquiry was to consider the impact of housing and homelessness on single people, a significant number of whom have complex needs, living unsettled and transient lives. The Panel examined the difficulties of delivering a preventative and planned approach to improve their health and wellbeing to reduce or minimise their health inequalities, supporting them to move into a settled and decent home. The Panel also examined the quality and impact of accommodation that single homeless people are most likely to move on to.

4. The rationale to focus on single homeless people stems from the high demand for single person's accommodation in the city, with over half of the 15,000 people on the housing register in need of single units. Homeless families and older people over 65 are much more likely to be accepted as homeless due to a priority need.

5. The objectives of the inquiry were:
    a. To understand how the current model for homelessness prevention supports and promotes better health outcomes for single people
    b. To recognise what works well and what needs to improve locally, learning from best practice nationally.
    c. To identify if there are any gaps or blockages in homeless prevention and health interventions for single homeless people.
    d. To explore how the Houses in Multiple Occupation (HMO) Licensing scheme contributes to the health and wellbeing of tenants who have been homeless, or at risk of homelessness, and what opportunities there are to provide further support by working in partnership with others.
    e. To explore the adequacy of single person accommodation and the effectiveness of the support pathway that leads to settled accommodation for those who have been homeless, in line with any existing contract periods.
    f. To consider further collaboration or invest to save opportunities that would prevent future increasing demand or reduce homelessness in the city, within existing budget constraints.

6. The full terms of reference for the Inquiry, agreed by the Panel, are shown in Appendix 1.

7. The Health Overview and Scrutiny Panel (HOSP) recognised the difficulties of achieving a paradigm shift in the lifestyle choices of individuals and that a proportion of the remaining clients are entrenched in the system. Sustaining housing is the first and only outcome that can truly be achieved for a number of these individuals – any further transformation will ultimately only come when those individuals are ready to change which may take time and a great deal of resources to support this to happen.

8. To this end, and recognising the current good practice alongside budget constraints and the challenges of the housing market, the Panel have identified some potential areas for improvement which they feel are realistic and achievable through either a shift of current resources or by considering invest to save opportunities.

CONSULTATION

9. The HOSP members undertook the Inquiry over six evidence gathering meetings between February and June 2014 and received information from a wide variety of organisations to meet the agreed objectives. Due to significant breadth and interest from potential witnesses an additional meeting was added to the end of the Inquiry, with the Inquiry recommendations and report agreed at the HOSP meeting on 25 September 2014.

10. During the Inquiry, many of the Panel members also visited a number of homeless providers to see the facilities and services first hand and talk directly to residents and staff about their experiences. The Chair of the Panel also attended the GP Forum and Southern Landlord Forum to obtain wider feedback on the issues and challenges being faced by homeless individuals and services. These visits were extremely insightful and highlighted the passion and commitment that exists to make a difference to homeless people.

11. A list of witnesses that provided evidence to the Inquiry is detailed in Appendix 2. Members of the Scrutiny Panel would like to thank all those who have assisted with the development of this review.

SUMMARY OF KEY FINDINGS AND ISSUES

12.
- An excellent and effective Homelessness Prevention Strategy, team and partnership has dramatically reduced homelessness over the last 10 years;
- The partnership has achieved significant outcomes within a framework of housing providers and support services with a common focus on prevention;
- However, a group of entrenched and costly individuals remain in the homeless system who have complex needs and behaviours;
- Existing health inequalities and complex needs are exacerbated by difficulties in accessing the right services, especially mental health and

substance misuse services which operate a high threshold due to limited resources and high demand;

- The complex needs and comorbidity of many homeless individuals mean that it is often their immediate problem that is resolved rather than the whole person;
- Staff in provider services show a passion and commitment to their clients but their views are not always heard by the professionals making decisions about their clients;
- GP practices requiring valid identification documents may prevent homeless individuals accessing the health services they need, thus potentially missing opportunities for earlier intervention and integration into community services;
- Homeless individuals are frequent users of hospital Accident and Emergency Departments, despite being registered and using the Homeless Healthcare Team or GPs;
- Access to emergency out of hours facilities, mental health and substance misuse services can be challenging, especially with referrals and transition into adult services for young people;
- The high demand for single unit council housing has led to a high reliance on the private rented sector and Houses in Multiple Occupation (HMOs);
- Housing is often unaffordable for single homeless people who are ready to move on, which means they are likely to live in poorer quality shared housing that they can afford;
- It is still too early to see the impact of the HMO Licensing scheme that aims to improve the condition of shared houses;
- The Housing Strategy focus on new affordable single units and increased dedicated student accommodation may eventually reduce pressures on the single rental market in the city;
- Social letting agencies are working with landlords to sign up to leasing schemes for homeless clients however there are perceived / potential barriers and few incentives to encourage landlords to take up these schemes.

SUMMARY OF RECOMMENDATIONS

Strategic city-wide approach to homelessness

i. That the Homelessness Prevention Strategy continues to support a city-wide approach and commitment for continued funding of the existing flexible partnership model of homelessness responses in the City.

ii. Commissioners undertake a feasibility study including a cost/benefit analysis, with providers, to consider whether a more intensive 'Housing First' model could provide the relatively small number but high cost entrenched homeless clients a potential route into sustainable and settled accommodation.

iii. The Housing Strategy continues to prioritise an increase in affordable single person accommodation across the City, including new developments.

iv. Links are maintained and strengthened between homelessness prevention and employment projects such as City Limits and the new City Deal to increase the skills and employment opportunities for homeless and vulnerably housed individuals.

Raising awareness, recognition and protection of valued services under threat

v. Continue to build relationships with landlords to raise awareness and common understanding of the issues and barriers of offering tenancies to homeless people and increase social letting with relevant support agencies. This includes bringing together the current range of city approaches for social lettings to the private sector housing rental market.

vi. Raise awareness of good practice and successful outcomes in homelessness prevention services as a means of reducing the stigma for homeless clients and encourage wider partnership involvement of other agencies including the Police and national Health Services including GPs and the University Hospital Southampton Trust.

vii. Expand the partnership to wider health services to reduce inequalities for homeless people services through delivering a comprehensive framework of preventative and integrated services.

viii. Raise the awareness of healthcare professionals of the role of homeless healthcare provider case workers and the value of their support of the single homeless, particularly through advocacy.

ix. Maintain an overview of the cost benefit of key valued services within the City's Homelessness model, including the Homeless Health Care Team and dedicated specialist services supporting substance misuse and mental health problems.

x. Consider outcomes from the Southampton Healthwatch review of GP registration and continue to work with GPs to improve access and integration to support homeless clients to move on from homeless health care to primary care services.

Improving Service Delivery

xi. The Homelessness Prevention Steering Group continue to support commissioners as they continue to progress towards an evidence-based and outcome-focussed commissioning model so that the case for changes in policy and practice can be evidenced.

xii. Children and Family Services continue to prioritise the Multi-Agency Safeguarding Hub or MASH and Early Help Team to ensure children in need are not falling though the gaps.

xiii. Children in Care continue to be a priority, particularly in preparing those in care to lead an independent life and that care leavers have access to suitable accommodation and maximise opportunities for employment, education and training alongside

xiv. Homelessness Services work with Hampshire Probation to support more pre-release planning to ensure emergency bed spaces are being used appropriately and to include looking at possibility of avoiding Friday prison releases.

xv. Commissioners of Homelessness services should consider the option of providing a 'dry' environment within the homelessness prevention model in the City to support those who want to become or stay sober.

xvi. Homelessness providers and commissioners should work towards developing 'psychologically informed environments' in hostels and develop a staff training programme as appropriate. Partnerships between the psychological support from the University and local housing providers are essential to achieving this.

xvii. Undertake a fundamental review of Mental Health services for the city, specifically including improving access to behaviour therapies for homeless clients and considering raising the age for transition for young people into adult services to 24/25 years old in line with the integrated substance misuse service. Early intervention should be prioritised alongside improving access to services from primary to acute care to ultimately reduce and better manage demand.

xviii. Investigate opportunities to reduce barriers and provide incentives for Houses in Multiple Occupation (HMOs) to be used for homeless clients

xix. Expand training on homelessness services / welfare services to community 1st responders and primary care services e.g. Hampshire Police, Ambulance Services, GPs and community nurses.

Monitoring and reviewing critical services and issues

xx. Undertake an evidence based review of the effectiveness of the HMO licensing scheme to ensure that standards of quality are maintained for all private sector tenants in the City and to support the decision making process for whether to expand the scheme to other wards in the city. It should be recognised that those who have been homeless will be moving on into the lower cost / quality end of the market where risks to their health remain high.

xxi. Regulatory Services to undertake a new stock condition survey to gain a better understanding of the quality of the City's private housing stock and establish mechanisms to secure an up to date survey at least every 6 years.

xxii. Integrated Drug and Alcohol Substance misuse service to report back to the Health Overview and Scrutiny Panel on how it will support homeless patients more effectively, particularly in relation the raising the transition age into adult services.

xxiii. Continue to monitor homelessness trends and impacts of Welfare Reforms on homeless people to enable evidence based responses and to adapt Local Welfare Provision where necessary and report the impacts of Welfare Reforms to commissioners and local agencies including the JobCentre Plus and the Department of Work and Pensions.

xxiv. The Homelessness Prevention Steering Group review the number, use and awareness of emergency weekend bed schedule for adults and especially for young homeless referrals and those discharged from hospital or custody.

xxv. Homelessness commissioners undertake a city-wide review of services which may come under threat due to lack of funding. Immediate consideration should be given to determine their value to the city's Homelessness Model and health outcomes for individuals for The Two Saints Day Centre and 'Breathing Space' project and the Vulnerable Adult Support Team in the Accident and Emergency Department of University Hospital Southampton.

A strategic approach to homelessness

13. The Homelessness Act (2002) requires local authorities to carry out a review of homelessness every five years, and use the findings to develop a strategy for preventing homelessness locally. The Council has recently published its third Homelessness Prevention Strategy, which sets out the current context for homelessness provision, achievements since the previous strategy, trends and priority actions going forward. The strategy has been developed in partnership with stakeholders, who have made a joint commitment to deliver the plans set out in the strategy.

14. The Southampton Homelessness Prevention Model supports clear and distinct pathways for young people, adults and older people, focussing on prevention and early intervention. Its effectiveness relies on established relationships and strong partnerships. The Panel heard from Homeless Link, the national membership charity for organizations working directly with homeless people in England, that Southampton operate a best practice homelessness prevention model. It ensures that Supporting People budgets, which are no longer ring-fenced, and homelessness prevention resources are being used to good effect. The Southampton homelessness services delivery model is attached at Appendix 4.

15. The Panel recognised that the partnership requires the current elements to be in place for the future to ensure the most effective and efficient use of resources. These include: early assessment, emergency provision, high/intensity support, case management approach (through the Street Homeless Prevention Team), young people's services and support for those with longer term needs.

16. The Panel acknowledged the progress achieved through the Homelessness Prevention Strategy and praised the dedication and commitment of the whole partnership. However, the Panel were particularly impressed by the following innovative projects, which have seen excellent results or provided exceptional support to vulnerable single homeless people:

    - The needle exchange has helped reduce infections from blood-borne viruses
    - The Naloxone programme has saved the lives of overdose victims
    - Two Saints introducing 'Psychologically Informed Environments' into their hostels
    - Breathing Space hospital discharge homelessness project providing medical support in a domestic setting
    - End of life support to enable homeless people to die with dignity in partnership with the Homeless Health Care Team and Patrick House
    - The Vulnerable Adult Support Team (VAST) set up in the Emergency Department of the University Hospital Southampton to give extensive support, time and signposting to appropriate services to people who present at A&E with no fixed abode.

17. Southampton's Homelessness Prevention Model has been effective in dramatically reducing the number of homeless applications and acceptances and reduced the use of temporary accommodation in the city over the last 10

years, providing a clear route for many homeless people to move into and stay in settled accommodation. Despite these best efforts and results an entrenched group of 'revolving door' clients remain who have complex needs and chaotic lifestyles who struggle to make progress or 'revolve' in and out of the system. These are primarily individuals who are expensive for public services often needing 24 hour care or supervision, frequent users of A&E, lack a sense of personal care / space and regularly involved in crime or anti-social behaviour.

18. The Panel heard from Adult Social Care that it is difficult to find cost-effective solutions for these clients. A number of housing providers cited the 'Housing First' model, where homeless clients are housed first in their own home and then given intensive support, as achieving dramatic results in the USA and Camden. When targeted at their most chaotic clients they have seen reductions in visits to A&E by a third, hospital admissions down by two thirds and nearly 75% still in their own home after 2 years.

19. The Southampton Homeless Prevention Model, is delivering a form of Housing First. When someone is assessed as homeless, they are housed first within a hostel, whilst an appropriate support package is determined. The Panel recognised that generally this works for most single homeless people but they believed that consideration should be given to whether a more intensive Housing First model could provide a more effective route for the entrenched group of individuals who have not progressed significantly or move on over a long period of time. The Panel recognised that this model would require the allocation of single units and resources for this specific purpose. However, the potential benefits of reducing high costs of 'revolving door' clients may outweigh the investment required.

20. Pressure on single housing units in the city is extensive. The Panel noted that 50% of the council's housing waiting list are for single units, with the cost of buying a home prohibitive for around 50% of residents who would be unable to enter the market without help. The Welfare Reforms are adding to the pressure on the housing. Changes to the Local Housing Allowance are creating pressures at the lower price end of the private sector rented market. The City's heavy reliance on private sector rented accommodation is unlikely to diminish in the medium term and the Panel recognised the importance of continuing the Housing Strategy's emphasis on affordable single units. The Housing Strategy has reprioritised its focus to increase the number of single affordable units in developments.

21. The Panel heard a consistent message from witnesses that the main triggers for homelessness include the loss of a home, job or benefits, offending, a mental health episode or other significant crisis. Clearly not everyone who experiences these issues will become homeless. However, where someone does become, or is at risk of homelessness, the Panel supports the principle and evidence that early intervention and prevention are crucial to avoid an individual becoming entrenched in the system. Support mechanisms are in place to provide homeless clients access to skills and employment when they are ready, although many single homeless people will be the most

removed from the work place and face significant barriers to entering employment.

22. Evidence to the Panel highlighted the desire that many homeless clients want to get (back) into work. The Panel recognised the importance of existing links for homelessness providers with employment and skills based projects in the City such as Adult Community Learning, City Limits and the new City Deal. These projects concentrate on increasing individual skills and on getting long term unemployed young people, disadvantaged people or those with mental health issues into work. With 7 out of 10 homeless people having at least one mental health condition, which often makes it slower for them to progress and move on to paid employment. The Panel felt that further consideration should be given to ensure the connections are in place. Enabling homeless clients to have good access to support into employment, will bring homeless clients closer to the work place, increases their life and health chances, and increase the likelihood of staying in their own home.

23. Although there are relatively few rough sleepers in the City, numbers have increased in recent years alongside national trends. A higher proportion of rough sleepers are from Accession States with no recourse to public funds. However, although they may access services and support at Cranbury Avenue Day Centre they are fearful of the UK Border Agency and may avoid accessing essential support services as a result. The Panel heard that most want to stay in the country and find work. However, where these individuals have no recourse to public funds they may find themselves on the street or in other unsustainable situations. The Panel supported the work of EU Welcome, who are funded to support migrants into work so that they do not spend a second night on the street.

24. With this evidence in mind the Panel have recommended that:

    i. The Homelessness Prevention Strategy continues to support city-wide commitment for continued funding of the existing flexible and innovative partnership model of homelessness in the city.
    ii. Commissioners undertake a feasibility study including a cost/benefit analysis, with providers, to consider whether a more intensive 'Housing First' model could provide the relatively small number but high cost entrenched homeless clients a potential route into sustainable and settled accommodation.
    iii. The Housing Strategy continues to prioritise an increase in affordable single person accommodation across the City, including new developments.
    iv. Links are maintained and strengthened between homelessness prevention and employment projects such as City Limits and the new City Deal to increase the skills and employment opportunities for homeless and vulnerably housed individuals.

Raising awareness and recognition of homelessness issues and protecting valued services

25. Southampton has historically had a high demand for shared private sector rented housing due to the number of students in the City. There is also a short supply of affordable single units. The average house price is out of reach for a higher than average level of low paid workers. In addition, as prices are cheaper in the City than surrounding areas this has added pressure on the demand for single units and shared housing. Welfare Reforms, including the changes to the Local Housing Allowance for private sector rented and the 'under occupation of social housing', is also adding to the strain on housing needs.

26. The South Hampshire Strategic Housing Market Assessment forecasts that an increase in dedicated student accommodation and higher targets for single affordable units may reduce the pressure on shared housing. But even if more affordable shared accommodation becomes available, many homeless clients may face additional barriers as they may be perceived as unreliable tenants due to their chaotic lifestyles and low or unstable incomes.

27. The Panel heard evidence from No Limits and Two Saints Real Lettings Agency who are working with landlords to offer a more stable package for homeless clients. They are brokering deals with landlords, offering pre-tenancy training with a period of support, leasing accommodation for longer periods, guaranteeing rents, and acting as a single point of contact for landlords if their tenants have any concerns or problems. This route is proving effective for single homeless people who are ready to move without support services such as a number of ex-offenders. The Panel believe this approach should be expanded; more social lettings would increase the housing options for single homeless people in the City.

28. Furthermore, the Panel felt that landlords have a social responsibility to view their tenancies as an ongoing relationship rather than a simple cash transaction. They acknowledged that a number of landlords already provide additional support to tenants, especially single tenants who are less likely to have a support network. The Panel agreed it is important that the Homelessness service continues to build bridges with landlords to increase their awareness of the risks of becoming homeless and take a more long term approach to support tenants who have been homeless. A better mutual understanding of the barriers to social letting should ultimately lead to more stable tenancies for single homeless clients in future.

29. As highlighted above, the Homelessness Prevention Strategy and partnership have achieved excellent results for homeless people in the city and provide exemplar services to support single homeless people into a settled home. However, a number of the witnesses highlighted the stigma that homeless people, and their case workers, experience accessing mainstream services.

30. The Panel noted the work that has been undertaken to promote the Homelessness Prevention Strategy, however, they felt that awareness and understanding of the excellent support services available was still patchy

across public sector organisations. Understanding of the issues and potential positive impacts of early intervention through homelessness referral services was potentially not as strong amongst other public services. Agencies who play an important part in the health and wellbeing of homeless people such as Jobcentre Plus, Police, GPs and hospital ward and A&E staff were not very aware of their role to support homeless people or the referral services available. Improving awareness and understanding of homelessness issues with these agencies would ensure better early intervention and community responses through more effective referrals to the right services.

31. Homeless people can experience barriers to accessing services. Case workers reported that barriers are often increased where they are not always enabled to effectively advocate on behalf of individuals or they were not listened to, despite having permission from their clients. The Panel heard that many single homeless people have underlying health problems but they may fall below the threshold criteria or present well on assessment. Case workers will often have a more informed view of their clients. This may lead to missed opportunities for early diagnosis leading to exacerbated symptoms if clients do not receive help. The Panel felt that case worker's opinions deserved greater recognition with health professionals. Increased awareness of homelessness issues and services and involvement of wider public services in the Homelessness Prevention Strategy Steering Group could lead to better understanding and wider support mechanisms for homeless people.

32. Due to the high prevalence of poor health issues, often with co-morbidity, for single homeless people the support of appropriate and early intervention of health services is crucial for the individual to reduce or limit health inequalities.

33. The Panel heard that Homelessness can be a cause or a consequence of mental health issues, with an estimated 60-70% of homeless people having some form of mental health problem. Patients often have a dual need or complex issues that may delay the management of recovery making the partnership between mental health and homelessness services essential to ensure adequate and ongoing support. Having a stable environment is critical for mental health patients and therefore the availability of adequate and safe housing when discharged from secondary care services is an important part of their recovery.

34. The partnership in Southampton is well established with Southern Health's Mental Health Housing Coordinator and Mental Health Accommodation Panel considering appropriate options for move on. However despite this the levels of patients in contact with mental health services in stable accommodation is very low at 28.5% for 2013/14, amongst the worst in the country.

35. The Panel also heard that mental health services are seeing more young people being admitted with accommodation issues; young people's homelessness provider case workers also highlighted they are finding it increasingly difficult to tackle the mental health issues of their clients.

Concerns were also raised that housing policy might exclude tenants who have had an undiagnosed psychotic episode.

36. The Panel recognised limited resources and a high demand for mental health services meant the threshold for treatment is set high. Support and access to appropriate mental health services as early as possible, however, is crucial to prevent or minimise the impact of homelessness. The Panel expressed serious concerns that the links between community support and acute mental health services are not as effective as they could be with a significant number of referrals being made through acute and urgent care services. Homeless patients are less likely to receive early intervention or treatment where relationships are not built with a GP. In addition, younger patients may be reluctant to access services, especially where transitioning to adult services.

37. The Panel was hopeful that the Better Care Southampton Plan will improve links for homeless people within communities through the GP clusters, however, in the meantime work needs to continue to reduce the stigma and raise awareness of the need for extensive support in the community for homeless mental health patients and where possible reduce the demand for acute levels of care for those at risk of homelessness through earlier intervention.

38. Southampton's Substance Misuse Services are developed in partnership and coordinated through the city's Integrated Commissioning Unit through transferred funding from Public Health and the Police. It was reported to the Panel that people with substance also have a high risk of housing problems which in turn leads to a high risk of relapse. The number of opiate users is increasing in the City and evidence suggests that stable accommodation can support their chances of successful treatment. Following a high number of overdoses in hostels, the Naloxone programme has successfully reduced harm and death. The Panel heard that for every pound invested in drug and alcohol treatment the public purse can save £2.50 and £5 respectively and supported the continued funding for substance misuse services, recognising the benefits this can bring to the life chances of homeless individuals.

39. The Panel acknowledged the central role of the Homeless Healthcare Team, delivered by Solent NHS Trust, in reducing health inequalities for homelessness people. It offers general health services alongside those more tailored to homelessness needs, operating from the Cranbury Avenue Day Centre. The co-location and effective partnership of these services has been critical in tackling the health needs of homeless people in the City, as well as providing essential outreach services to hostels. The Homeless Healthcare Team resources are limited however and with over 500 homeless patients on their register the service is overstretched.

40. GP registration can be difficult for homeless people who may not have valid identification papers where requested by GPs to avoid the risk of duplication and over-subscribing to patients. For many homeless individuals the cost of having, or risk of losing, a passport for example can be prohibitive or appear unnecessary. This issue prolongs the reliance on the Homeless Healthcare Team rather than integration within community services when clients have

moved on. The Panel urged GPs and practice managers to recognise the benefits for the wider health system of enabling homeless patients to register without ID and work to find alternative ways of checking the identification of individuals, particularly, homeless patients, to ensure they can continue to access healthcare in the community and avoid the risks of continued exposure to the drinking / drugs culture of homelessness services.

41. To address the above issues the Panel recommend that the Homeless Prevention Steering Group work with partners to prioritise and deliver the below actions given current resources and capacity:

    v. Continue to build relationships with landlords to raise awareness and common understanding of the issues and barriers of homeless tenancies and increase social letting with relevant support agencies. This includes bringing together the current range of city approaches for social lettings to the private sector housing rental market.

    vi. Raise awareness of good practice and successful outcomes in homelessness prevention services as a means of reducing the stigma for homeless clients and encourage wider partnership involvement of other agencies including the Police and National Health Services including GPs and the University Hospital Southampton Trust.

    vii. Expand the partnership to wider health services to reduce inequalities for homeless people services through delivering a comprehensive framework of preventative and integrated services.

    viii. Raise the awareness of healthcare professionals of the role of homeless healthcare provider case workers and the value of their support of the single homeless, particularly through advocacy.

    ix. Maintain an overview of the cost benefit of key valued services within the City's Homelessness model, including the Homeless Health Care Team and dedicated specialist services supporting substance misuse and mental health problems.

    x. Consider outcomes from the Southampton Healthwatch review of GP registration and continue to work with GPs to improve access and integration to support homeless clients to move on from homeless health care to primary care services.

Improving service delivery

42. The Panel heard from homeless service providers and the University of Southampton Psychology Department that services can be driven by targets to move someone on within a given timescale. However, while this is the case in the City, there are adequate safeguards to ensure that people are not moved on too quickly. However, for homeless people, changing behaviours (e.g. incidences of antisocial behaviour, drug and alcohol use etc.) are the most tangible of outcomes for many homeless individuals.

43. Commissioning of services according to realistic and meaningful outcomes is essential. Service providers need to be clear what will change as a result of

what they do. In this way, providers may be encouraged to think creatively about their areas of expertise in delivering tangible and measurable change. Monitoring these outcomes could contribute to a culture of evidence-based commissioning, where services are clear with commissioners about expected outcomes, and commissioners then hold the services to that contract.

44. The Panel supports an evidence-based approach to homelessness provision as this enables a mixed economy of housing providers to sustain additional projects to support vulnerable homeless people alongside council funded services.

45. The Panel noted that research at the University of Southampton identified that a key factor of homelessness links to childhood neglect and abuse. This can lead to difficulties in managing emotions, and partly explains the high level of mental health problems and addictive behaviours of homeless people. Housing support services for young people reflected that their support workers are not trained to provide support for mental health needs of their clients and are finding it increasingly difficult to meet their needs.

46. The Panel also heard that Southampton homelessness services have seen increasing numbers of a younger aged clients, although they tend to sofa surf rather than sleep rough. There are clear separate pathways established to avoid young people entering adult services where possible.

47. Historically, the proportion of care leavers in suitable accommodation and employment has been low but following a priority focus to address this performance has improved, through signing up to the Care Leavers Charter and Staying Put arrangements but the position needs to continue to improve. The Panel recognised the benefits of increased support to care leavers up to the age of 24 and support the continued priority to improve outcomes and life chances for care leavers to break the cycle of homelessness and ensure they are better prepared for independent life.

48. The Panel, however, were concerned about vulnerable children and young people under the radar now, and in the future, who need to be prevented from escalating into the homeless system later in life due to a lack of support network, increasing risks of poor mental health or substance misuse.

49. The Panel noted that Children and Families Services are going through substantial improvement and transformation and through the establishment of Early Help Team and the new Multi-Agency Safeguarding Hub (MASH). The Panel recognised these services aim to provide an effective team and expertise, connecting to both public sector and voluntary services, in a timely and effective manner to ensure that children do not fall through the system or that dangerous individuals are not hidden. The Panel will continue to monitor the progress of these new services to ensure that they achieve the desired outcomes for future generations of vulnerable children.

50. The Panel heard from Hampshire Probation Services that access to stable accommodation is the most important factor in avoiding repeat offending, however, Homelessness Prevention Services often find release dates are on a Friday which means their accommodation needs are difficult to resolve. Probation are also working to secure better health outcomes for ex-offenders

and in considering the general wellbeing of clients alongside access to accommodation and benefits they have already seen successful outcomes.

51. Although drinking and drugs are monitored and managed in hostels, the Panel were concerned that a lack of a 'dry house' in the system can cause problems for homelessness people who want to detox. All the Southampton hostels allow alcohol consumption on the premises and although residents can exercise their own free will, it can often be too much of a temptation for someone with an addiction, especially if coupled with mental health problems. Dry houses have proved effective in the Offender Management Programme and the Panel would like to learn the lessons from these services and for commissioners to consider an alternative option is currently feasible to reduce the harm to those homeless clients who want to be sober.

52. The Panel heard repeatedly from witnesses of the problems experienced by homelessness clients accessing mental health services either due to long waiting lists for services, especially cognitive behaviour therapy (CBT). They will often fall below the threshold criteria for services, present well on assessment or are refused treatment whilst under the influence of alcohol or drugs due to potential conditions such as Korsakoff's Syndrome.

53. The University of Southampton have undertaken extensive research over the last 8 years with the Society of St James, Two Saints and the Booth Centre (Salvation Army) to evaluate effective psychological interventions to treat their clients' issues.

54. Their research has found that behaviour therapies that take a skills approach to the treatment of emotion management can be very effective in increasing functioning of people experiencing complex mental health difficulties. These interventions have enabled them to operate better in a structured 'hostel' environment and move on in a more sustainable way.

55. They have found that with training, housing providers can enable hostel staff to establish 'psychologically informed environments' where they can better understand and support behaviours more effectively, enabling the process of real change. Although it is recognised that these outcomes take time to embed, Two Saints, who have been working to establish this within Patrick House, are already seeing positive results with their clients.

56. Despite this potential improved support for the mental health of homelessness clients the Panel remained concerned about the overall capacity of the current Mental Health provision to deal with the growing mental health needs of the City. There was particular concern for young people accessing mental health services, where early signs of mental health issues are most likely to occur and respond effectively to intervention.

57. Where homeless people remain untreated it is clear that their mental health can deteriorate, often with increasing psychotic episodes. If this pattern of poor access to mental health services is being replicated across the city, given that Southampton has one of the highest anti-depressant prescription rates, there is clearly an underlying issue for mental health commissioning that needs to be addressed.

58. The Panel therefore supports a fundamental review of mental health services in the City to identify better ways to manage current demand and provide earlier help to avoid escalating health problems in the future, which may need a more acute response.

59. The Panel also remained concerned that the support available for Young People with mental health problems was not meeting the demand, given that problems are most likely to occur at this stage and treatment is most effective through early intervention. The Panel heard that the transition into adult mental health services can be very difficult for young people, with many not progressing into the system but resurfacing later with more acute mental health problems and often at high risk of homelessness. To reduce this escalation of need for mental health support, and ultimately homeless prevention services, the Panel would like to see the age threshold for mental health services raised in line with the integrated substance misuse service and Staying Put model for care leavers to provide more effective and widely integrated early intervention model for young people to a later age of at least 24 years old.

60. The chair of HOSP and two social letting agencies attended to the Southern Landlord's Forum to gauge the interest in expanding opportunities for social letting in the City. Although there was an enthusiastic response to the opportunities for increased social letting, landlords raised some concerns about the legality of signing up to long term leases and that the limits of the HMO Licensing Scheme might restrict opportunities in certain areas. The Panel, however, were optimistic that social letting could expand if the barriers could be removed or incentives provided in the scheme to enable more private sector tenancies and HMOs to be used as social letting for specific vulnerable groups such as single homeless people.

Recommendations

61. To address the above issues the Panel have recommended that:

xi. The Homelessness Prevention Steering Group continue to support commissioners as they continue to progress towards an evidence-based and outcome-focussed commissioning model so that the case for changes in policy and practice can be evidenced.

xii. Children and Family Services continue to prioritise the Multi-Agency Safeguarding Hub or MASH and Early Help Team to ensure children in need are not falling though the gaps.

xiii. Children in Care continue to be a priority, particularly in preparing those in care to lead an independent life and that care leavers have access to suitable accommodation and maximise opportunities for employment, education and training alongside

xiv. Homelessness Services work with Hampshire Probation to support more pre-release planning to ensure emergency bed spaces are being used appropriately and to include looking at possibility of avoiding Friday prison releases.

xv. Commissioners of Homelessness services should consider the option of providing a 'dry' environment within the homelessness prevention model in the City to support those who want to become or stay sober

xvi. Homelessness providers and commissioners should work towards developing 'psychologically informed environments' in hostels and develop a staff training programme as appropriate. Partnerships between the psychological support from the University and local housing providers are essential to achieving this.

xvii. Undertake a fundamental review of Mental Health services for the city, specifically including improving access to behaviour therapies for homeless clients and considering raising the age for transition for young people into adult services to 24 in line with the integrated substance misuse service. Early intervention should be prioritised alongside improving access to services from primary to acute care to ultimately reduce and better manage demand.

xviii. Investigate opportunities to reduce barriers and provide incentives for Houses in Multiple Occupation (HMOs) to be used for homeless clients

xix. Expand training on homelessness services / welfare services to community 1st responders and primary care services e.g. Hampshire Police, Ambulance Services, GPs and community nurses.

Monitoring and reviewing critical services

62. The Panel heard repeated evidence of the clear link between good housing and good health. Regulatory Services undertook a Stock Condition Survey in 2008 which identified that 38% of the 25,000 private homes in the City did not meet the Decent Homes Standard, primarily due to overcrowding or inadequate facilities. The service also investigates complaints and carries out risk based inspections to ensure that private housing in the City is safe, warm and secure.

63. The Stock Condition Survey is now six years old, and concerns were raised, by the Panel and landlords, over the reliability of this data. The Panel felt that the timing was right to undertake a new Stock Condition Survey, and to renew the survey at least every 6 years. The Panel acknowledged the resources implications of undertaking this survey, however, they felt that reliable information on the quality of the City's housing stock was crucial, given the reliance on the private sector market in the City.

64. 7% of the City's homes are estimated to be Houses in Multiple Occupation (HMOs), which is 5 times the national average. HMOs are usually shared houses of 4 or more people averaging between 16 and 34 years old. With the high reliance on HMOs for moving homeless clients on and given changes to the Local Housing Allowance the Panel accepted that people who have been homeless are more likely to rent at the lower end of the market and experience poorer quality housing, exacerbating any existing poor health conditions they may already have. The Panel recognised that there are good and bad landlords, however, they were concerned that tenants in lower quality housing are less likely to report issues for fear of the landlord increasing the rent or ending the tenancy.

65. The Panel heard that the HMO Licensing Scheme aims to work with landlords to improve overall conditions, management and basic health and safety for shared homes in the City. The scheme is currently being rolled out to 4 wards in the City, Portswood, Swaythling, Bevois and Bargate, where it is estimated that there are 4,500 HMO properties. To date just over a third

of these properties have applied for a licence voluntarily; with the enforcement stage commencing in 2014/15 the service continue to gain a better understanding of the quality and compliance issues in these areas.

66. A number of witnesses highlighted the poor conditions that many ex-homeless people were living in and the Panel heard that the HMO Licensing Scheme would identify and deal with non-compliant landlords who let properties in a poor or dangerous condition or who have poor management arrangements. The Panel acknowledge that here may be merit in expanding the scheme across the City, to ensure all shared houses are of an acceptable quality, however, the Panel felt that how and when this expansion takes place should be based on the evidence and outcomes from HMO Licencing in the first four wards and supported by an up to date Stock Condition Survey.

67. Given the high level of substance misuse and dependency by single homeless people the Panel were encouraged to see a new integrated Drug and Alcohol Substance Misuse Service was expected to be in place by July 2014. Hostels were particularly concerned that they were not receiving as much outreach support and were sometimes finding it difficult to cope with the addiction of their clients and associated behaviours. The Panel believed that the new integrated service would enable resources to be placed more effectively and were keen to see how this new integrated service would offer better support to homelessness services in future, including outreach services and raising the age for young people to transfer to adult services.

68. The Panel recognised that monitoring systems were well established for the Homelessness Prevention Strategy. However, evidence to the Panel suggested that the full impacts of the Welfare Reforms may not have materialised yet in the City, particularly around changes to the Local Housing Allowance (LHA) and the under occupation of social housing. The Panel heard that homeless individuals, with complex needs and chaotic lifestyles, was more likely to fail to comply with their claimant commitment resulting in an increased risk of having their benefits sanctioned. This is likely to have a devastating impact on their ability to cope. Further Welfare Reforms expected in the next 2 years, including the continued transition from Disability Living Allowance (DLA) to Personal Independence Payments (PIP) and the roll out of Universal Credit (UC), will have serious implications for homeless individuals.

69. Monitoring of the impacts of Welfare Reforms is underway with key agencies through the Welfare Reforms Monitoring Group. However, with major changes still to come housing providers and the Homelessness Prevention Team need to ensure that they are continuing to assess, record and share the impacts on their clients and services to ensure the Local Welfare Provision can respond to these changes and provide an evidence-based response to commissioners, the Jobcentre Plus and Department of Work and Pensions.

70. Although access to homelessness assessments and referrals is relatively straight forward and well understood during the week, some referral agencies found it difficult to access beds for discharge from hospital out of

hours. This can cause significant problems for single homeless people who will have limited support mechanisms to turn to. The Panel also heard that if Probation Services release an individual from custody on a Friday with no pre-release liaison, the individual is less likely to settle and will be more likely to reoffend. Conversely, an emergency bed may be reserved in a hostel for an ex-offender which does not get used, blocking it from other potential clients. The emergency bed situation was cited as particularly difficult for young people services, where bed spaces are more limited. The Panel felt that the availability of emergency bed spaces needed to be reviewed with referral partners. A better understanding of the issues being faced by all services would ensure a more effective 'out of hours' service can be provided and used.

71. The Panel heard that a number of best practice services have time limited funding or are under threat of funding being withdrawn. However, it was clear that these services are making a tangible difference to the lives of homeless people. These services include:

- The Vulnerable Adult Support Team in the hospital A&E department who have reduced frequent attendance and supported over 200 patients to homelessness services that would otherwise have been back on the streets. Short term funding was agreed by the Hospital Trust but is due to end in September 2014.
- The Breathing Space Project was established through funding from the Department of Health and works with the University Hospital Trust to provide medical support in a domestic setting. The project has seen dramatic life changes with entrenched homeless individuals who have been given time to recover in a safe environment. This funding is due to end in October 2014.
- The Cranbury Avenue Day Centre, run by Two Saints provides an established and effective central homeless hub for the City. The Homeless Link transition funding and Council funding ends in March 2015.

72. The Panel felt that a city wide review should be undertaken to identify the cost benefit of these services to key public agencies to ensure that a sustainable funding plan is developed to keep them operating. This may include the need for short-term funding while this is being evaluated.

Recommendations

73. To address the above issues the Panel have recommended that:

xx. Regulatory Services complete an evidence based review of the need to extend the HMO licensing scheme to other wards in the city to ensure that standards of quality are maintained for all tenants in the city, in recognition that those who have been homeless will be moving on into the lower end of the market where risks to their health remain high.

xxi. Regulatory Services undertake a new stock condition survey to gain a better understanding of the quality of the City's private housing stock and establish

mechanisms and resources to secure an up to date survey at least every 6 years.

xxii. Integrated Drug and Alcohol Substance misuse service to report to the Health Overview and Scrutiny Panel on how changes to service delivery will support homeless people more effectively, particularly in relation to raising the age of transition into adult services.

xxiii. Continue to monitor homelessness trends and impacts of Welfare Reforms on homeless people to enable an evidence based response to adapt the Local Welfare Provision where necessary and report the impacts of Welfare Reforms to commissioners, the Jobcentre Plus and the Department of Work and Pensions.

xxiv. The Homelessness Prevention Steering Group review the number, use and awareness of emergency weekend bed schedule for adults and especially for young homeless referrals and discharge from hospital or custody.

xxv. Homelessness commissioners undertake a city-wide review of valued services which may come under threat due to lack of funding. Immediate consideration should be given to determine their value to the city's Homelessness Model and health outcomes for individuals for The Two Saints Day Centre and 'Breathing Space' project and the Vulnerable Adult Support Team in the Accident and Emergency Department of University Hospital Southampton.

Conclusion

74. There is an established and effective Homeless Prevention Strategy with a strong partnership delivering good services for the City. This partnership, however, needs to expand to wider health services and other agencies working with homeless people such as the Hospital, Police and Probation to be more effective.

75. There are many excellent services in operation across the City but single homeless individuals continue to suffer health inequalities and remain amongst the most marginalised residents, suffering many barriers to accessing the services. Increasing the understanding and awareness of other agencies who refer and deal with single homeless people should lead to more effective support and signposting and referral for individuals. Dealing with the mental health and substance abuse of homeless individuals, especially with earlier intervention for young people, is critical to them moving on. In addition, the lack of any 'dry' houses in the City can limit the options and willpower of those who want to be sober.

76. A large proportion of homeless clients have been through the care system or suffered abuse or neglect at a young age, which will impact on their behaviour and emotions. Work underway to transform the life chances of care leavers and multi-agency approach to providing early help will hopefully reduce the homelessness of future generations of children in need through early intervention.

77. There remains an entrenched group of individuals in the system who are hard to move on or relapse frequently who due to their complex needs and behaviours. These clients are expensive to the public purse and

consideration should be given to whether more intensive Housing First model would make a difference for these individuals.

78. The Panel recognises the difficulties of achieving a paradigm shift in the lifestyle choices of individuals. The homelessness prevention model in operation enables many homeless people to move on but for many move on from homeless services needs time and access to the right support mechanisms and treatment. Sustaining housing is the first and only outcome we can truly achieve for a number of these individuals – any further transformation will ultimately only come when they are ready to change.

Appendices

Appendix 1 – Inquiry Terms of Reference

Appendix 2 – Inquiry Plan

Appendix 3 – Summary of Key Witnesses

Appendix 4 – Southampton Homelessness Model and outline of key services

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		UNIVERSITY HOSPITAL SOUTHAMPTON; EMERGENCY DEPARTMENT REPORT		
DATE OF DECISION:		25 SEPTEMBER 2014		
REPORT OF:		CHIEF EXECUTIVE, UHS		
CONTACT DETAILS				
AUTHOR:	**Name:**	Jane Hayward	**Tel:**	023 8079 6241
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Director	**Name:**	Fiona Dalton, Chief Executive UHS	**Tel:**	023 8077 7222
	E-mail:	fiona.dalton@uhs.nhs.uk		

STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY

The University Hospital Southampton's Chief Operating Officer, Jane Hayward, will provide the Panel with an overview of last year's performance and latest position against the Emergency Department accident and emergency targets. She will also provide a verbal update on the plans in place to achieve targets during winter 2014/15 and preparation for the inspection of the trust in December 2014.

RECOMMENDATIONS:

(i) That the panel notes the progress to achieve A&E targets at the University Hospital Southampton, and following discussions agrees any issues that may need to be brought forward to a future HOSP meeting.

REASONS FOR REPORT RECOMMENDATIONS

1. As part of the HOSP's terms of reference the panel has a role to respond to proposals and consultations from NHS bodies in respect of substantial variations in service provision.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None

DETAIL (Including consultation carried out)

3. At the last panel meeting on 24th July 2014 the hospital outlined the latest UHS Emergency Department's performance. It was agreed by the panel to receive an update at future HOSP meeting until the situation at the emergency department is resolved. The latest update is attached at Appendix 1.

4. A verbal update will also be given at the Panel meeting to provide an overview of the overall performance of the hospital and an outline the preparation for the inspection due in December 2014

5. The Panel are asked to note the latest performance and consider any issues that may need to be brought forward to a future HOSP meeting.

RESOURCE IMPLICATIONS

Capital/Revenue

6. None

Property/Other

7. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

8. The powers and duties of health scrutiny are set out in the Local Government and Public Involvement in Health Act 2003.

Other Legal Implications:

15. None

POLICY FRAMEWORK IMPLICATIONS

16. None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	ALL

SUPPORTING DOCUMENTATION

Appendices

1.	UHS: Emergency Department performance

Documents In Members' Rooms

	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

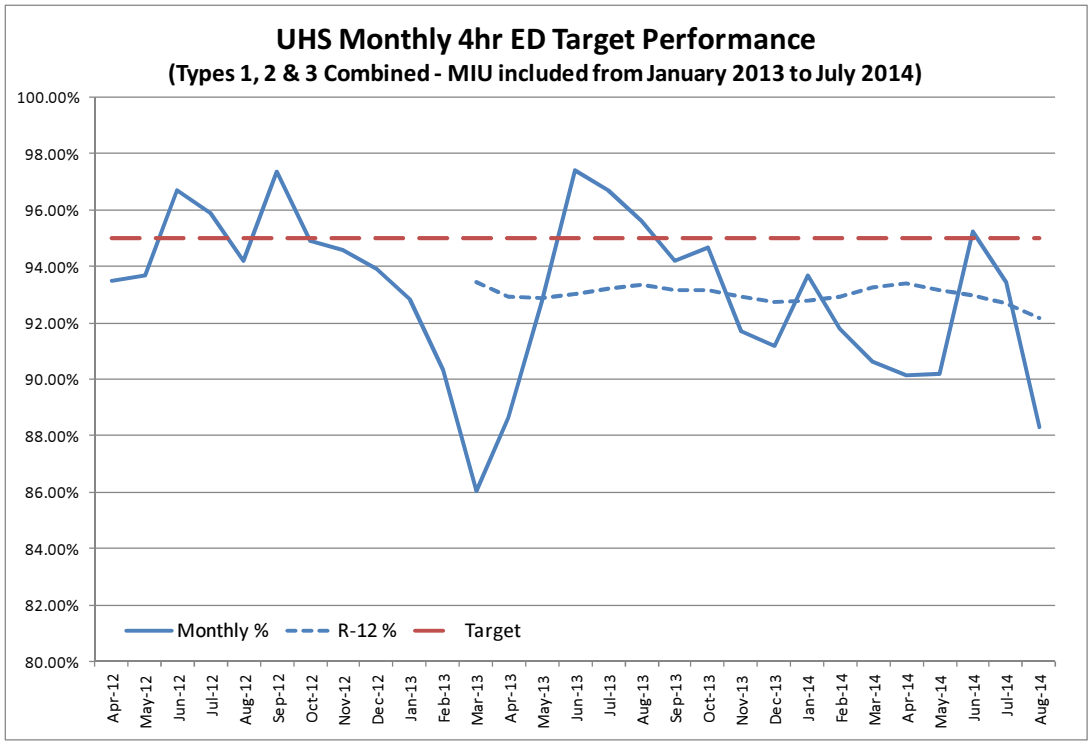
	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

University Hospital Southampton NHS
NHS Foundation Trust

Emergency Department Report for Overview and Scrutiny Panel – September 2014

The Trust is monitored on its ED performance across all emergency departments – the main SGH Emergency Department (a Type 1 Dept.), Eye Casualty (a Type 2 Dept), and until August 1st when management was transferred, the RSH Minor Injuries Unit (a Type 3 Dept).

Whilst the Trust met the target to treat and admit or discharge more than 95% of patients within 4 hours during June 14, this performance has not been sustained during July and August of this year.



It should be noted that the removal of the MIU data from August makes it significantly harder for UHS to achieve the 95% target. Nationally, Type 1 Emergency Departments have not collectively achieved the ED 95% target in any given week for over a year. In most weeks the national performance for Type 1 EDs is between 92% and 93%.

As can be seen in the table below, in England Newcastle is the only major teaching hospital (taking major trauma etc) to consistently achieve this target for Type 1 activity.

Week Endir	UHS	Birmingham	Bristol	Cambridge	Leicester	Newcastle	Nottingham	Oxford	Sheffield
06/04/2014	78.0%	96.6%	94.7%	89.9%	77.1%	95.5%	86.4%	86.2%	97.4%
13/04/2014	83.7%	96.3%	93.5%	92.9%	77.4%	96.8%	87.0%	93.8%	96.8%
20/04/2014	86.3%	95.1%	95.0%	93.9%	90.3%	97.7%	92.5%	90.3%	98.1%
27/04/2014	84.0%	95.4%	92.4%	89.1%	70.7%	95.3%	84.5%	88.7%	92.8%
04/05/2014	84.6%	95.8%	91.7%	89.9%	77.7%	95.8%	88.9%	94.7%	94.4%
11/05/2014	80.7%	95.9%	92.0%	88.5%	75.2%	98.2%	86.3%	89.8%	97.0%
18/05/2014	83.9%	95.3%	92.2%	88.5%	70.9%	97.5%	85.6%	90.9%	92.6%
25/05/2014	86.9%	95.7%	95.0%	87.3%	69.8%	97.7%	85.8%	90.7%	89.7%
01/06/2014	83.6%	95.3%	94.5%	93.0%	72.6%	95.0%	87.7%	89.1%	93.5%
08/06/2014	86.4%	95.3%	97.3%	88.7%	79.5%	95.2%	84.5%	89.7%	95.7%
15/06/2014	94.2%	93.3%	90.7%	87.8%	84.7%	97.8%	88.3%	94.2%	94.1%
22/06/2014	95.7%	94.6%	94.8%	89.5%	89.9%	98.7%	82.5%	89.0%	95.0%
29/06/2014	93.5%	93.9%	95.3%	86.2%	89.9%	96.8%	79.7%	91.2%	95.2%
06/07/2014	92.5%	94.5%	90.5%	85.9%	92.1%	98.2%	85.0%	91.7%	94.2%
13/07/2014	92.7%	95.4%	91.2%	88.4%	83.4%	95.9%	84.3%	95.5%	94.2%
20/07/2014	86.3%	96.0%	89.7%	92.6%	86.4%	98.4%	85.6%	90.8%	93.8%
27/07/2014	88.5%	95.5%	92.6%	92.4%	85.9%	96.7%	84.2%	96.4%	92.5%
03/08/2014	85.9%	94.3%	91.2%	95.3%	91.0%	98.1%	83.6%	93.4%	89.2%
10/08/2014	89.2%	95.0%	90.2%	91.0%	83.4%	97.1%	88.7%	92.8%	96.7%
17/08/2014	85.4%	92.9%	91.5%	92.3%	80.3%	96.6%	86.9%	96.7%	97.7%
24/08/2014	91.9%	93.9%	95.4%	96.4%	92.0%	94.7%	92.1%	93.1%	96.3%

College of Emergency Medicine
The College of Emergency Medicine launched their national campaign "Exit Block" last week. It is worth looking at the video link. : *Exit Block: Tackling exit block."*

This short video shows the problems that occur in ED when onward flow into the hospital is blocked. They include delays to ambulance hand-over and breaches of the 4 hour access target. The "exit block" is due to delays to patients being admitted, treated efficiently and discharged. In the video the whole hospital are shown "owning "the problem, from porters to Chief Executive.
At UHS we are similarly committed to addressing the problems by involving the whole hospital and by:

1. Addressing flow within the ED
2. Supporting rapid admission into hospital where necessary
3. Reducing delays to patient discharge once they are fit to leave, to allow sufficient bed stock for admissions.

1. Emergency Department Processes

Some patients have not had their treatment completed within 4 hours and we are working on improving the systems and processes within ED . The Trust has agreed a plan with the CCG commissioners to improve the performance in ED. In brief:

A) We will increase the staffing in ED. We have invested this year in new doctors to look after children in the ED and to help create a new team to manage a separate Children's ED when this is completed. We have also invested in a team of nurses to look after patients with fractures and injuries. This will complement our partnership with the Minor Injuries Unit at the RSH.

B) We will change our processes so that diagnostic investigations can be undertaken as quickly as possible. We are building a team of experienced nurses to receive patients as they arrive in the ED to initiate all necessary tests and pain relief within 20 minutes of arrival. This is known as the "pitstop" model and is successfully used in some other UK ED's..

C) We will review the use of our Clinical Decision Making Unit (CDU) and our other pathways that help avoid admission including the creation of a new pathway for elderly patients to ensure they can be seen by specialists from this field.

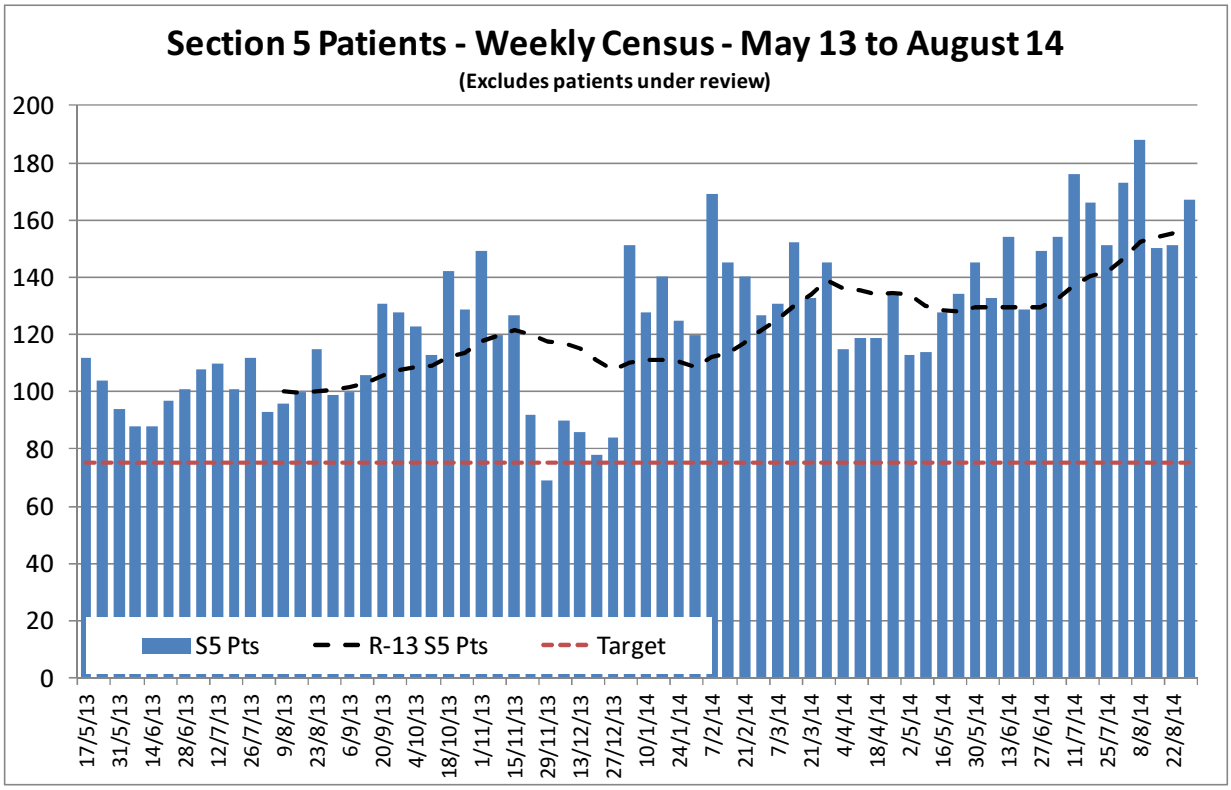
2. Supporting Rapid Admission

We will ensure if patients do need to be admitted to a Hospital bed that this process is as simple as possible for the patients, their families and the staff.

- We have created a senior team of clinicians to ensure that admission decisions can be made with minimal delay
- We are creating rapid admission pathways for some common conditions

3. Bed Availability

Bed availability is the primary problem for UHS during the winter months, as this prevents patients from being admitted from the Emergency Department in a timely manner. Normally this pressure reduces during the summer but this pattern has not been seen this year. The hospital has been under sustained pressure all summer and in part this is due to the ongoing rise in Section 5 patients (complex discharges).



The number of medically fit patients (section 5 patients) has peaked at 176 patients in August, almost 16% of the total bed stock. The health and social care system's plan is to introduce new pathways for patients to allow them to undertake complex assessments to determine the type of care the patient needs and how this will be funded in a community bed, this is known as discharge to assess. At the same time Hospital staff will become trusted assessors and will be able to support social services teams to complete some of their tasks in facilitating hospital discharge. UHS staff are being trained by social services in late September 2014 and hope to be able to start "Trusted Assessment immediately afterwards.

This will then support and be supported by the new pathways and ways of caring for patients being delivered through the Better Care Fund plans to introduce locality working and new out of hospital services.

These words below are from the draft Better Care Plan submission and as such they represent our consensus as a healthcare community:

“Taking pressure off the acute hospital sector remains a priority of the local health and social care system. In 2012, following sustained difficulty in maintaining the national A&E waiting time standard (of 95% of people being admitted or discharged within four-hours), the Emergency Care Intensive Support Team (ECIST) carried out a review of provision both within UHS and across the wider health and social care system. They concluded that, despite some successes, there had been an over-reliance on schemes to avoid admission and insufficient emphasis on improving discharge planning and onward care. In essence they concluded the whole health and care system needed to change from a culture of trying to ‘push’ people out of hospital to release capacity, to one where community services intervened to help ‘pull’ patients through by means of pre-planning effective community or home-based support. Our Better Care plans reflect this focus.

Throughout 2013, it became clearer that sustained very high levels of bed occupancy (in excess of 95%) were creating difficulty in admitting patients in urgent need, and creating unacceptable risks to the safety and quality of patient care across the hospital. We are starting to see a decline in the number of A&E attendances and there is some evidence that the growth in emergency admissions has been stemmed. There is renewed determination across the whole system to build on progress, to sustain efforts to alleviate these problems and to support the hospital in every way possible. However, performance against the 95% standard remains less than acceptable and this is important because this standard is a key indicator of challenges across the entire system: failure to safely and effectively discharge people leads to significant pressure on elective capacity which in turn means that meeting other crucial national standards (such as referral to treatment times and waiting times for cancer) becomes challenging. Delayed transfers of care remain high in Southampton and we have seen significant growth in the beginning of 2014/15 compared to 2013/14. “

We welcome the united approach to this problem and are keen to work closely with our partners to ensure that patients are managed in the most suitable setting for their needs.

At the same time as the changes for patients with ongoing care needs we will open additional beds to compensate for the increase in demand and the growing length of stay. Over and above this we plan to continue to open additional virtual beds by creating new community provision.

Fiona Dalton
Chief Executive

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY COMMITTEE		
SUBJECT:		ADULT SOCIAL CARE TRANSFORMATION		
DATE OF DECISION:		25 SEPTEMBER 2014		
REPORT OF:		Alison Elliott		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Alison Elliott**	**Tel:**	**023 8083 2602**
	E-mail:	**alison.elliott@southampton.gov.uk**		
Director	**Name:**	**Alison Elliott**	**Tel:**	**023 8082 2602**
	E-mail:	**Alison.elliott@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY

In January 2013 the Council embarked on a transformation programme of the People Directorate, which included Adult Social Care. The principles of the transformation programme were improving outcomes for services users, maximising independence, reducing demand for services and making better use of resources. The redesign of Adult Social Care went live in April 2014 with the exception of the expanded front door.

RECOMMENDATIONS:

(i) To note the contents of the report requested by the Scrutiny Panel

REASONS FOR REPORT RECOMMENDATIONS

1. Report requested by HOSP

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None

DETAIL (Including consultation carried out)

3. It had been recognised that there were great opportunities for providing improved outcomes, services and cost reductions through the formation of the People Directorate.

4. One focus of the People Directorate Transformation was Adult Social Care.

5. There was clear evidence that in the Adult Social Care redesign the greatest opportunities for improved outcomes and reduced costs were in the way services are commissioned, the interface with customers at the 'front door' and the delivery of effective enabling services, particularly IT.

6. Adult Social Care continues to place a high demand upon resources, demographic changes and the introduction of the Care Act will only serve to increase demand.

The redesign of Adult Social Care was therefore driven by the need to

improve outcomes but also manage demand.

7. The front door, once agreed, will provide better information, advice and guidance in line with the duties placed upon the local authority in the Care Act. The single front door will be able divert and sign post a greater number of people to alternative services. It will ensure customers' needs are met at their first contact without be passed between teams. Decisions regarding eligibility, respite provision, increases and decreases in care will all be made at the front door.

8. Following an eligibility assessment at the front door most (80%) people who are eligible will receive a reablement service. This service works with individuals for a maximum of 6 weeks to maximise their independence. A new team of Occupational Therapists and care managers now work with CCFS to deliver reablement with a target of ensuring 60% of people receiving reablement no longer require long term care. There are capacity issues with the service so not as many people as we would like are able to access it but their performance is currently at 66%. There are plans to increase the capacity by improving productivity and co-locating with the Rapid Response service currently provided by Solent Healthcare.

9. For those people (20%) for whom reablement is not an option assessment and support planning is provided by our long term teams, one focusing on older people and one focusing on people with a learning disability.

   Adult Social Care have historically not undertaken statutory annual reviews. Therefore, a dedicated Review Team has been created with an action plan to address the backlog and then undertake reviews in a timely way that ensures care provided is meeting the needs of the individual.

10. A dedicated Safeguarding Team has been established to ensure the safeguarding focus is on the individual not on the provider or provision of service. A senior practitioner is also based in the Multi-Agency Safeguarding Hub to ensure adult's needs are identified and any adult safeguarding issues are addressed

11. The Hospital Discharge Team takes referrals direct from the hospital and focuses on ensuring safe, timely discharge. This team has struggled to meet demand and delayed discharges of care have increased as a result. A new team manager is now in place and creative plans have been developed with the hospital to enable nurses to discharge those people whose needs have not changed, without the need for a social work assessment. The hospital are also recruiting a manager of the Hospital Discharge Bureau to ensure coordination across the disciplines.

12. The redesign has been challenging for staff and it is clear that communication with staff should have been better. The delay in the introduction of the front door has also provided a challenge as the redesign was based on having a functioning front door in place from April 2014.

    The development of the Integrated Commissioning Unit (ICU) has been important in the redesign of Adult Social Care. The pooled budget and recommissioning of Carers Services will ensure carers continue to be supported.

13. The development of a placement team has resulted in care being commissioned by the ICU, freeing up social workers to focus on assessments and support planning. It also ensures commissioners are getting the best value for money and are able to manage the market more effectively, addressing the gaps in capacity. This service is currently operational for the Hospital Discharge Team and Reablement and will be expanded to all teams by January 2015.

14. The 0 – 25 service for children with special educational needs and disabilities (SEND) went live on the 1st September 2014 and will be expanded to include all children and young people with disabilities from April 2015. This will ensure that children and their families will be supported to prepare for adulthood much earlier and is a joint development from Children & Families and Adult Social Care supported by the ICU to ensure that a multi-agency service is developed.

15. Adult Social Care is about to pilot the use of laptops and tablets to facilitate mobile working. This pilot will support the development of a business case to expand mobile working across the Directorate.

16. The Better Care Fund will have further implications for Adult Social Care and is discussed in a subsequent paper.

17. Adult Social Care performance has improved as a result of the redesign in the following areas:

- There has been a 20% reduction in admissions of older people to residential care compared to the same period in 2013 (April – July).
- Permanent admissions to residential care have been reduced by 14.8%.
- The number of people receiving community based reablement has increased by 92.4% (1,106 in 2013 to 2,128 in 2014).
- The percentage of people receiving community based reablement who did not receive long term support during the reporting year increased by 13.7%.
- The average length of waiting time at the Single Point of Access decreased from 42 days in 2013 (April – August) to 13 days during the same period in 2014.
- The average length of waiting time in all teams (excluding LD) decreased from 58 days to 22 days.
- The number of people with long term care plan reduced from 4,051 in 2013 to 3,801 in 2014 (April – August).

RESOURCE IMPLICATIONS

Capital/Revenue

18. None

Property/Other

19. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

20. None

Other Legal Implications:

21. None

POLICY FRAMEWORK IMPLICATIONS

22. None

KEY DECISION? Yes/No

WARDS/COMMUNITIES AFFECTED:	No

SUPPORTING DOCUMENTATION

Appendices

1.	None

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY COMMITTEE		
SUBJECT:		BETTER CARE SOUTHAMPTON UPDATE		
DATE OF DECISION:		25 SEPTEMBER 2014		
REPORT OF:		CABINET MEMBER FOR HEALTH AND ADULT SOCIAL CARE		
CONTACT DETAILS				
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STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY

Southampton submitted its initial Better Care Fund (BCF) local plan on 4 April 2014. Since then there have been some changes to the national policy framework underpinning Better Care and further national guidance has been issued by the Local Government Association and NHS England. Health and Wellbeing Board areas have been required to submit revised plans by 19 September 2014.

The revised BCF planning guidance and technical guidance documents set out what has changed in more detail. In summary, the previous £1bn Payment for Performance framework has been revised so that the proportion of the £1bn that is now linked to performance is dependent solely on an area's scale of ambition in setting a planned level of reduction in total emergency admissions (i.e. general and acute non-elective activity). Plans are also required to demonstrate evidence of robust finance and activity analytical modelling and to show strong provider and partner engagement and alignment to their plans.

This briefing provides an update on the status of Southampton's plan which will be submitted on 19 September 2014.

RECOMMENDATIONS:

(i) Health Overview and Scrutiny Committee notes progress towards implementation of Better Care Southampton.

REASONS FOR REPORT RECOMMENDATIONS

1. As part of comprehensive spending review in summer of 2013 the Chancellor of the Exchequer announced that nationally a sum of £3.8 billion would be set aside for 2015/16 to ensure closer integration between health and social care. This funding was described as "a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and Local Authorities. It should be noted that this is

not new money; the funding will be top sliced from existing budgets. Local authorities and the clinical commissioning group (CCGs) were required to submit a plan setting out how the pooled funding will be used to improve outcomes for patients, drive closer integration and identify the ways in which the national and local targets would be met.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None. Each Health and Wellbeing Board in England is required to submit and deliver a plan developed jointly by the council and CCGs.

DETAIL (Including consultation carried out)

3 **Summary of Southampton's Better Care Fund Plan**

3.1 Better Care Southampton plan was approved by the Health and Wellbeing Board in March 2014, with strong stakeholder support. The revised plan follows the same direction of travel.

3.2 There is a strong case for change. A higher proportion of older people in Southampton rely on input from social services than is the case nationally (5.2% compared with 3.8%). CCG spend on acute activity is 54% and growing, rates of unplanned admissions and delayed transfers are above the national average, pressure on beds is unsustainable and unsafe and there are high rates of admission to residential and nursing homes. This is against a backdrop of rising need (The over 65s population is set to increase by 11% and the number of people over 85 years from 5400 to 6100 between 2012 and 2019. There are increasing numbers of people living with long term conditions). The changing needs of the population are putting increased pressure on health and social care at a time when resources are reducing. Legislative changes, for example the duties posed by the new Care and Support Bill, are also requiring services to identify need earlier and respond to a national minimum eligibility threshold.

3.3 The vision for Better Care is to completely transform the delivery of care in Southampton so that it is better integrated across health and social care, delivered as locally as possible and person centred. People will be at the heart of their care, fully engaged and supported where necessary by high quality integrated local and connected communities of services to maintain or retain their independence, health and wellbeing. Neighbourhoods and local communities will have a recognised and valued role in supporting people and there will be a much stronger focus on prevention and early intervention.

3.4 Our overall aims are:

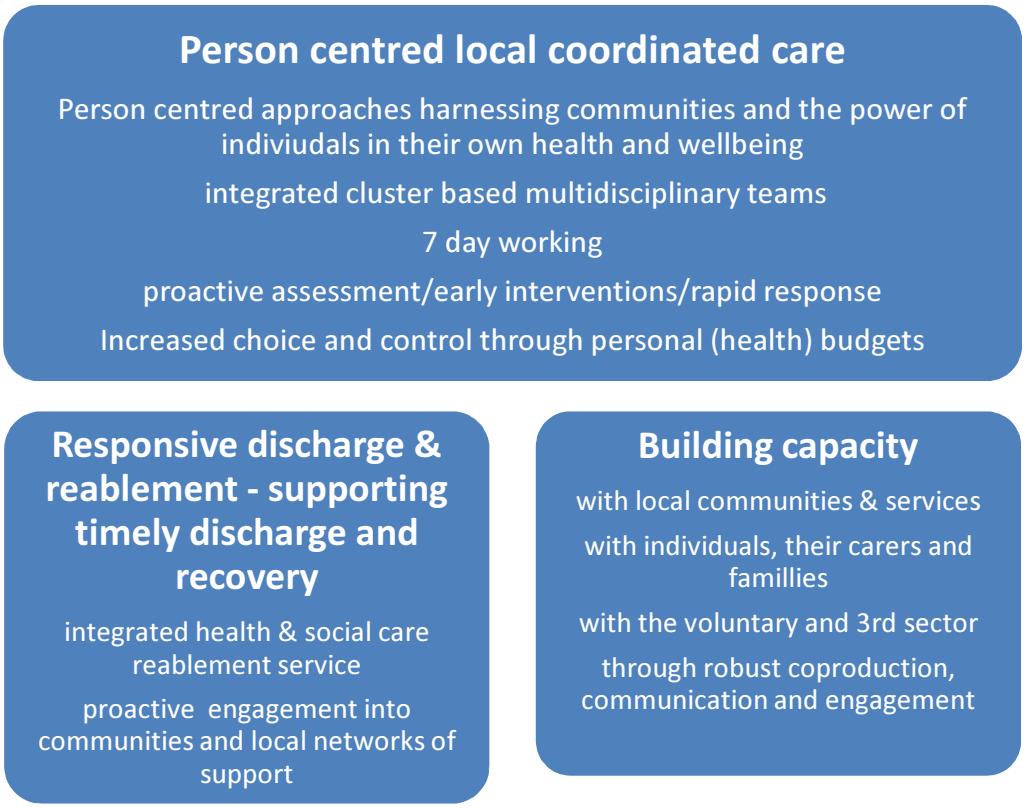
- Putting people at the **centre of their care**, meeting needs in a holistic way
- Providing the **right care, in the right place at the right time**, and enabling people to stay in their own homes for as long as possible
- Making **optimum use of the health and care resources** available in the community, reducing duplication and closing gaps, doing things once wherever appropriate
- **Intervening earlier** in order to secure better outcomes by providing more coordinated, proactive services

3.5 **Underpinning these aims are the following national conditions:**

- protecting social care services
- 7 day services to support discharge from hospital
- data sharing
- Joint assessment and accountable lead professional for high risk populations

All of these elements have been developed within the plan. An element of funding will be available to protect social care to ensure that resources are available to provide appropriate support for those who meet the current eligibility criteria and effective signposting for those who do not. The key focus for achieving this though, within the challenge of growing demand and increasing budgetary pressures is to reduce the demand being made on social care. This is through the development of integrated approaches to identify need and intervene earlier as well as helping people regain their independence and through this reduce the need for ongoing care

3.6 **Our approach to system redesign has 3 basic components:**



3.7 There are 6 main schemes:

- **Local person centred coordinated care** - integrated multidisciplinary cluster teams providing integrated risk stratification, care coordination, planning, 7 day working – this will impact on those people most at risk of hospital admission or long term care who will benefit from case and disease management, roughly 5% of our population (around 12,000 people), but also support those at more moderate risk (35,500 people) who would benefit from supported self care. The majority of this target group will be older people (65+) and those with multiple long term conditions.

- **Long Term Conditions pathways** – supporting local person centred coordinated care – key areas of focus are COPD, given the high proportion of respiratory admissions, and diabetes. We are reviewing how specialist teams focussed on specific long term conditions can better support the more holistic model of local person centred coordinated care we are aiming to implement.
- **Integrated discharge, reablement and rehabilitation** service, including greater use of telecare/telehealth. This scheme is aimed at helping people to maintain their independence at home, in the community, intervening quickly where required to prevent deterioration, as well as supporting people's recovery and reablement following a period of illness. The scheme will particularly focus on reducing long term admissions to residential and nursing homes and preventing delayed transfers of care.
- **Community development** – this scheme is aimed at developing local community assets and supporting people and families to find their own solutions. This is key to the overall development of our local person centred coordinated care model.
- **Supporting carers** – this scheme recognises the important role that carers have in supporting older people and those with multiple long term conditions in the community and supports the overall model and ambitions of local person centred coordinated care. This will support the new eligibility framework within the Care Act where, for the first time, councils will be under a duty to provide support for carers who have eligible needs. Initial modelling work suggests that between 5% (249) and 25% (1243) carers providing 50 or more hours of unpaid care per week will request an assessment of need in 2015. As awareness increases over 2015, it is anticipated that a further 5-10% of carers will request an assessment of need in 2016.
- **Developing the market for placements and packages** – this includes work to develop the market to provide greater opportunity and choice, encourage a recovery/ reablement focus and support people to remain as independent as they can be in their own homes.

4. Progress

There is already significant momentum in delivering the Better Care programme.

- We have consulted on and agreed 6 local cluster areas, based around GP practice populations, through which integrated care will be delivered.
- Significant work has been done across the system on reviewing discharge processes. The trusted assessor model is being rolled out with inreach coordinators and discharge facilitators being trained to assess, restart and set up simple packages. Discharge to assess is also being implemented with 12 beds commissioned in the nursing home sector to support this.
- A concept paper for a more integrated model of rehabilitation and reablement is currently being consulted on.
- Additional information, advice and support services for carers have

been commissioned and have gone live in September 2014.

- The domiciliary care tender is progressing with new contracts due to go live in February 2015.

5. **Targets**

Southampton's Better Care plan seeks to achieve the following:

- **Reduce unplanned hospital admissions** - We aim to reduce our number of unplanned hospital admissions by 2% year on year over the next 5 years (3% when population growth is factored in). The payment for performance element of the Better Care fund is based on this reduction. The national planning assumption is that this will be in the region of a 3.5% reduction in 2015/16 against the previous year (with no allowance for population growth). The rationale for a lower target is that, whilst reducing avoidable unplanned hospital admissions is a key priority, our focus for Better Care in Southampton is on reducing pressures in the whole of the health and social care system, supporting people to stay safe and healthy in their own homes and communities. This is supported by recent reviews of our health and social care system such as the Emergency Care Intensive Support Team (ECIST) review which concluded that, despite some successes, there had been an over-reliance on schemes to avoid admission and insufficient emphasis on improving discharge planning and ongoing care in the community.
- Significantly **reduce permanent admissions to residential and nursing homes** - Our aim is to achieve a 7.1% reduction in admissions in per capita terms over 2014/15; 9.7% over 2015/16 and sustain and improve on this in subsequent years.
- **Increase the percentage of older people still at home 91 days post discharge into reablement services** - we are already performing well on this metric (87%) and are aiming to sustain this level of good performance in 2014/15, increasing to 90% in 2015/16 whilst acknowledging an increasingly complex population.
- Significantly **reduce delayed transfers of care** - Delayed transfers of care (DTOC) are high in Southampton and we have seen significant growth in the beginning of 2014/15 compared to 2013/14. Our plan for 2014/15 is therefore to hold this growth for the remainder of the year at the 2013/14 level and to further reduce delayed transfers in 15/16 by an additional 3 per day. This will return levels of DTOC to the 13/14 position, an approximate 10% reduction.
- **Reduce injuries due to falls** - our aim is to reduce the number of injuries due to falls requiring hospitalisation per week by 12.5% by the end of 2014/15 and sustain and improve on this in subsequent years.

6. **Consultation and Governance**

6.1 There has been significant consultation over the last 10 months in the

development of the Better Care plan with a broad range of stakeholders. Key to the success of Southampton's Better Care plan is strong engagement and co-production of the model. Health Provider organisations have had to confirm detailed and meaningful provider involvement in the development of the plan, demonstrate clear alignment between the overarching BCF plan and the provider plans and demonstrate a shared understanding of the critical path to successful delivery

6.2 The Integrated Care Board, with broad stakeholder membership oversees the development and implementation of Southampton's Better Care plan. The Board reports to the Integrated Commissioning Board with member, clinician and senior officer representation from both the Council and CCG. The Health & Wellbeing Board provides high level oversight of these arrangements, ensuring that partnership arrangements are effective and that plans are robust and both ambitious and realistic in their aspiration.

RESOURCE IMPLICATIONS

Capital/Revenue

7. Southampton intends to take a holistic approach to out of hospital health and social care and fund and commission it in that way. Our ambition is to encompass all services that fit within the scope of the Better Care model.

Organisation	Contribution to pooled fund (£000) 2014/15	Contribution to pooled fund (£000) 2014/15
Southampton City Council	924	56,008
Southampton City CCG Minimum Contribution		15,325
Southampton City CCG additional contribution	1,286	59,786
TOTAL	**2,210**	**131,119**

A draft Section 75 agreement is being complied. The finalised pooled fund agreement will progress through appropriate organisational approval. It is not required until 2015/16.

Property/Other

8. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

9. NHS England Publications Gateway Ref. No.00314

Other Legal Implications:

10. None.

POLICY FRAMEWORK IMPLICATIONS

11. Align with Health and Wellbeing Strategy and Council's Policy Framework Plans

KEY DECISION? Non

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	None

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		OFSTED ACTION PLAN		
DATE OF DECISION:		25 SEPTEMBER 2014		
REPORT OF:		HEAD OF CHILDREN AND FAMILIES SERVICE		
CONTACT DETAILS				
AUTHOR:	**Name:**	Christine Robinson	**Tel:**	**023 8083 4669**
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STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY

On July 7th OFSTED undertook a second unannounced inspection of Southampton Children's Services and Southampton Local Safeguarding Children's Board (LSCB) over a period of three weeks. This followed the previous inspection which had been declared by Ofsted to be flawed. The report of inspection with their findings and improvements required has now been published. The improvements that have followed the transformation programme were acknowledged by the inspectors and they deemed the leadership and management of the service to be strong.

However due to there being insufficient evidence yet of the impact of the changes to Children's Services and the LSCB, both were overall judged to Require Improvement. In addition the Leaving Care service was deemed to be inadequate due to systemic failures in the multiagency commitment to this group of young people. Ofsted identified a number of issues that need to be addressed before Children's Services' could be considered to be good. The appendices include the Ofsted Inspection report of Children's Services and the LSCB review and the improvements required. Ofsted will re-inspect Southampton Children's Services in 12-18 months' time and will expect to see all the actions completed and the service demonstrating that it is a good service. Children's services have accepted Ofsted's offer to work together to devise an effective action plan to ensure that services for children in Southampton are good.

RECOMMENDATIONS:

(i) The committee note the Ofsted Inspection report and the LSCB review report

(ii) The committee review the action plan when it is complete and agree an approach to monitor progress

REASONS FOR REPORT RECOMMENDATIONS

1. This Ofsted Report is a statutory requirement and it is important that it is subject to the scrutiny of the Panel and has ownership by the Council

2. The Panel needs to be aware of the concerns that need to be addressed and the requirement to address these concerns

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. It is a statutory requirement to respond to the Ofsted Inspection report and produce an action plan and that there should be sufficient scrutiny by the council. One of the requirements identified by Ofsted is that scrutiny of Children's Services by Southampton City Councillors should be improved. Therefore no other actions were considered.

DETAIL (Including consultation carried out)

3. The report contains the findings of a thorough inspection of Children's Services, which included consultation with service users and staff. The report highlights that services require improvement because:

    a) Politicians have not been meeting their corporate parenting responsibilities to champion looked after children and care leavers and ensure that their needs are met.
    b) Too many care leavers are not in education, employment and or training. Only three care leavers are currently in higher education.
    c) Over 30% of care leavers are either not in touch with services or assessed as living in unsuitable accommodation.
    d) Adoption is not achieved quickly enough for a small minority (17%) of looked after children.
    e) Care plans for looked after children are neither thorough nor comprehensive and therefore are not effective in assisting practitioners in their work to ensure that all children's needs are being met.
    f) The majority of looked after children do not receive good quality life story work.
    g) Looked after reviews are too often delayed or not held at the right time
    h) Arrangements to respond to children who go missing from home and care are not sufficiently robust.
    i) Strategy discussions do not always include all appropriate agencies and are poorly recorded.
    j) Case recording is often not sufficiently detailed nor purposefully linked to the care plan of the child.
    k) The supervision of social workers does not consistently promote reflective practice.
    l) Performance management arrangements are not sufficiently focused on improving the quality of work with children and families.

4. Under each of these points detail is provided of what the local authority needs to do to improve the services for children and the council is required to publish an action plan within 90 days in order to move from 'requires improvement' to 'good'.

5. The inspectors noted the ambitious improvement programme and the transformation programme, in particular that:

    "This inspection found substantial evidence that this programme is beginning to have a positive impact in transforming practice, and that this is beginning to improve outcomes for vulnerable children in a number of key areas."

6. However, the leadership management and governance of the local authority is not yet good as, despite significant progress, there are elements of improvement needed, that are not yet in place. For example, services for care leavers are inadequate; strong corporate parenting is not embedded or

demonstrating impact; tracking and risk management for children missing from home and care are not robust; performance management is an improving area of work but is not yet sufficiently focused on improving quality; and the quality and frequency of professional supervision are not sufficiently consistent. Although significant success has been achieved in reducing reliance on agency social workers, challenges remain in securing a sufficiently experienced, skilled and permanent workforce throughout the organisation. Political scrutiny arrangements have not been effectively applied to key areas of children's services.

RESOURCE IMPLICATIONS

Capital/Revenue

7. There are no capital costs to these proposals and it is anticipated that revenue costs will fall within the existing budget for Children's Services. Successful implementation of the required changes have the potential to lead to reduced costs in the future as children's needs are met earlier and there will be less demand for placements for looked after children

Property/Other

8. There is no impact on property in the Action Plan

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

9. All the actions in this report fall within the statutory powers already accorded to Children's Services. Ofsted, as a statutory body, has required an improvement in the delivery of Southampton Children's Services and Southampton City Council Children's Services is required to comply

Other Legal Implications:

10. There are no other legal implications

POLICY FRAMEWORK IMPLICATIONS

11. There are no Policy Framework Implication

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	The Ofsted Inspection report applies to children in the whole of Southampton

SUPPORTING DOCUMENTATION

Appendices

1.	Ofsted Report on Southampton Children's Services including Southampton LSCB July 2014

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

Southampton Council

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

and

Review of the effectiveness of the local safeguarding children board[1]

Inspection date: 8 July 2014 - 30 July 2014

Report published: 15 September 2014

The overall judgement is that children's services require improvement
The authority is not yet delivering good protection and help and care for children, young people and families. It is Ofsted's expectation that, as a minimum, all children and young people receive good help, care and protection.[2]

The judgements on areas of the service that contribute to overall effectiveness are:		
1. Children who need help and protection		**Requires Improvement**
2. Children looked after and achieving permanence		**Requires Improvement**
	2.1 Adoption performance	**Requires Improvement**
	2.2 Experiences and progress of care leavers	**Inadequate**
3. Leadership, management and governance		**Requires Improvement**

[1] Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspection Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.
[2] A full description of what the inspection judgements mean can be found at the end of this report.

Contents

The local authority

Summary of findings

Children's services in Southampton require improvement because:

1. Politicians have not been meeting their corporate parenting responsibilities to champion looked after children and care leavers and ensure that their needs are met.
2. Too many care leavers are not in education, employment and or training. Only three care leavers are currently in higher education.
3. Over 30% of care leavers are either not in touch with services or assessed as living in unsuitable accommodation.
4. Adoption is not achieved quickly enough for a small minority (17%) of looked after children.
5. Care plans for looked after children are neither thorough nor comprehensive and therefore are not effective in assisting practitioners in their work to ensure that all children's needs are being met.
6. The majority of looked after children do not receive good quality life story work.
7. Looked after reviews are too often delayed or not held at the right time
8. Arrangements to respond to children who go missing from home and care are not sufficiently robust.
9. Strategy discussions do not always include all appropriate agencies and are poorly recorded.
10. Case recording is often not sufficiently detailed nor purposefully linked to the care plan of the child.
11. The supervision of social workers does not consistently promote reflective practice.
12. Performance management arrangements are not sufficiently focused on improving the quality of work with children and families.

What does the local authority need to improve?

Priority and immediate action

Care Leavers

13. Take action to reduce the numbers of care leavers living in unsuitable accommodation and ensure that all such arrangements are robustly risk assessed and monitored.

14. Ensure that all cases where care leavers are not in contact with services are regularly reviewed and that there are effective responses to all opportunities to re-establish contact.

15. Improve support for care leavers to encourage and sustain engagement in education, employment or training.

Missing Children

16. Ensure that information from 'return home' interviews is routinely shared and used to improve the quality of safe care planning for children. Improve the quality and analysis of data on children going missing from home and care.

Adoption

17. Complete the review of children waiting for adoption and ensure that appropriate alternative plans for achieving permanency are implemented for the small number of children for whom adoption is no longer an appropriate option.

Areas for improvement

Care Leavers

18. Improve support for care leavers to engage them and to sustain their engagement, in education, employment or training.

19. Ensure appropriate services are available to support improved attainment of all care leavers.

20. Increase the number of care leavers successfully attending higher education.

21. Ensure that preparation for the transition into adulthood begins early enough, and is informed by a good needs assessment.

22. Improve the availability of health promotion and advice to care leavers.

23. Expand the range and availability of suitable accommodation options and eliminate the use of unsuitable provision such as bed and breakfast accommodation.

24. Ensure that care leavers have a good understanding of their rights and entitlements.

25. Establish a comprehensive set of policies, procedures and practice standards to support social workers and personal advisors to improve the quality of services to care leavers.

Looked After Children

26. Ensure that children's care plans are outcome focused and sufficiently address all of a child's assessed needs.

27. Improve the quality, consistency and recording of direct work undertaken by social workers with looked after children.

28. Ensure that all looked after children who require it receive good quality and timely life story work.

29. Ensure that all looked after children can receive support from an advocate or independent visitor.

30. Improve the timeliness of looked after reviews, and ensure that the records of these reviews are circulated promptly.

31. Strengthen arrangements to consult with looked after children and young people. This work should include consideration of the support arrangements for the Young People in Care Council and expanding the range and age of children involved in consultation.

32. Increase the involvement of the virtual school in Personal Education Plan (PEP) meetings to promote the most effective use of pupil premium funding to improve the educational attainment of looked after children.

Adoption

33. Further improve the timeliness with which children progress into adoptive placements.

34. Accelerate the rate at which adopters are recruited and assessed to meet the demand from children who need a permanent family.

Help and Protection

35. Ensure that all relevant agencies are involved in strategy discussions and meetings, and that these discussions clearly record decisions, rationale and planning of Section 47 enquiries.

36. Improve the quality of assessments so that these reflect children's daily experiences.

37. Improve the quality and consistency of recording of child protection visits so that they clearly reflect the aims of the child protection plan.

38. Improve child protection plans so that they more clearly focus on key areas of risk and how this will be reduced and include contingency planning.

39. Develop systems to identify and quantify the number of child protection cases within which adult substance misuse and mental health issues feature significantly.

40. Increase the participation of older children in child protection processes.

41. Ensure that the provision of S20 accommodation and the availability of looked after services are appropriately considered and discussed with homeless 16 and 17 year olds.

Governance

42. Ensure that members robustly and consistently champion the needs of looked after children and care leavers.

43. Develop the role of scrutiny within the City to ensure that the wider multi-agency arrangements for the provision of early help and services to children and their families from children's social care, are routinely considered by political leaders.

Performance Management

44. Further develop performance management arrangements to provide analysis of the quality of work being undertaken and drive improvements in service quality

45. Ensure there is sufficient capacity and skills within the Independent Reviewing Service to provide consistent quality assurance and robust challenge of the work it reviews.

Workforce

46. Continue to review the sufficiency of the social care workforce so that workloads are manageable and allow front line workers and managers to meet required standards.

47. Ensure that all social workers receive consistently good quality and regular supervision that includes professional development, case reflection and appraisal.

The local authority's strengths

48. The local authority has a good understanding of its strengths and weaknesses and of the needs of its community. Leaders are both challenging and ambitious in their aspirations for Southampton's vulnerable children and are backing this ambition with clear, focused and appropriately resourced action planning.

49. Children and families can access support from a wide range of early help services and those with more complex needs receive well-coordinated and, when necessary, more intensive support.

50. The local authority's troubled families project (Families Matter) is helping many families with entrenched difficulties to improve their care and parenting. This work is now well integrated with other early help and targeted support.

51. An effective MASH has been established which is enabling good inter-agency information sharing and decision making at the first point of contact with statutory social care services.

52. Children with child protection plans are visited and seen regularly by social workers who have a good understanding of their needs, wishes and feelings.

53. Child protection conferences are well managed and make good use of the 'Strengthening Families' model and tools.

54. Workers and managers have a strong awareness and understanding of domestic abuse issues, and there is a good range of support services for victims of abuse.

55. The Jigsaw service provides comprehensive, integrated and effective support for disabled children and children with complex health needs.

56. The communication between the out of hours and day time services is robust, ensuring that families receive a seamless service and all emergency activity is followed up promptly.

57. Public law outline processes are consistently well-applied and are supporting timely decision-making about whether children need to become looked after; they also contribute to reduced timescales for completing care proceedings.

58. A large majority of looked after children are living in families with carers who are well supported and committed to meeting their needs. Placement stability is better than the national average.

59. Good attention and support is provided to keeping brothers and sisters together.

60. Looked after children receive good support to engage in leisure and social activities.

61. The Behaviour Resource Service (BRS) provides very good quality interventions and support for looked after children with therapeutic needs. Looked after children can also access good support if they have difficulties with substance misuse.

62. Integrated commissioning arrangements for children's services, including placement commissioning, promote the good use of pooled resources and services, which are well matched to children's needs.

Progress since the last inspection

63. Safeguarding and looked after children's services in Southampton were last inspected in April 2012. That inspection judged overall effectiveness for both safeguarding and looked after children to be adequate but quality of provision in both these areas to be inadequate. The early signs of improvement identified by that inspection were neither consolidated nor built upon. This meant that in April 2013 the local authority's self-assessment found children were not safe or properly protected from significant harm, and looked after children received a service that was not consistently good enough. This analysis was supported by leaders in Southampton and by findings from serious case reviews.

64. From a self-assessment position where children were not being reliably protected or having their welfare promoted, leaders and managers have taken swift, robust and effective action to improve services. As a result no cases of children receiving inadequate protection were identified during this inspection. Evidence of more historic practice evaluated during this inspection also supported that analysis. Many examples were seen of previous poor practice and decision making, leading to missed opportunities to protect children and failures to achieve permanence for children within their timescales. Workforce instability has also led to children experiencing many changes of social worker, which both delayed care planning and prevented children from developing trusting relationships with their workers.

65. In response to these failings, leaders have taken decisive action to improve services and outcomes for children. These have included establishing multi-disciplinary early help teams, creating a MASH (Multi Agency Safeguarding Hub) and implementing a workforce strategy which has substantially reduced social worker turnover and the reliance on agency staff. Equally importantly, it has sought to transform the culture in which services operate by creating a common ownership of safeguarding across its partnerships, and making practice more evidence based and child focused.

66. This inspection saw much evidence of the positive impact of these changes in the conduct and presentation of staff and increased workforce stability, in the feedback from partner agencies, including schools and most significantly in the practice that was observed and evaluated.

67. Actions to transform looked after services are clear and progressing, but improvements are less advanced. They are building on foundations which include some significant strengths (such as placement stability and quality) as well as significant deficits. Progress to improve services for care leavers has been poor and these services remains inadequate because of the poor outcomes experienced by many care leavers. Current senior leaders and managers have a clear understanding of the scale and nature of improvement required and are beginning to implement plans to deliver services to a consistently high standard.

Summary for children and young people

- Services to help and protect children and young people have been poor in Southampton and not all looked after children and care leavers have received a good enough service. Those in charge of these services have recognised this and are doing a lot to improve them, which means that children are now better protected. Children and their families are now receiving help before problems become too great.
- Social workers visit and listen to children and take account of their views, but do not always think enough about what their actual daily lives are like. When children go missing from home or care, they are visited by someone to listen to their views and try and understand why they are going missing, but this person does not always talk to the child's social worker.
- Social workers try hard to find adoptive families for every child who needs one, but sometimes this can take too long.
- Looked after children nearly all live with their brothers and sisters when this is what they want and have good foster carers who care about them, but children looked after are not always given enough help to understand what has happened to them in their lives.
- The young people in care council has some great ideas about improving the lives of looked after children, but it needs more support to get more children involved in its work.
- Many young people leaving care like and feel supported by their individual workers but because of weaknesses elsewhere these efforts do not result in good outcomes for care leavers. Young people leaving care do not receive enough help and support with their education or training and too many are not in education or do not have a job. Good accommodation is not always available for young people leaving care and too many are living in unsuitable housing.

Information about this local authority area[3]

Children living in this area

- Approximately 46,149 children and young people under the age of 18 years live in Southampton. This is 20% of the total population in the area.
- Approximately 25% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - *in primary schools is 22 % (the national average is 18.1%)*
  - *in secondary schools is 21% (the national average is 15.1%).*
- Children and young people from minority ethnic groups account for 20% of all children living in the area, compared with 21.5% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Asian/Asian British.
- The proportion of children and young people with English as an additional language:
  - *in primary schools is 22% (the national average is 18.1%).*
  - *in secondary schools is 18 % (the national average is 15.1%).*
- Southampton has a higher proportion of larger families (consisting of three or more children) than the national average and most of its statistical neighbours.

Child protection in this area

- At 31 March 2014, 235 children and young people were the subject of a child protection plan. This is an increase from 232 at 31 March 2013.
- At 30 July 2014, 24 children lived in a privately arranged fostering placement. This is an increase of 16 from the 8 identified at 31 March 2013.

Children looked after in this area

- At 31 March 2014, 500 children were being looked after by the local authority (a rate of 105 per 10,000 children). This is an increase from 482 at 31 March 2013 (104 per 10,000 children). Of this number:
  - *239 (49%) live outside the local authority area but 87% of these are placed within 20 miles of their home address*
  - *12 live in residential children's homes, of whom 9 live out of the authority area*

[3] The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data where this was available.

- *2 live in residential special schools*[4]*, and both live out of the authority area*
- *408 live with foster families, of whom 212 (54%) live out of the authority area*
- *25 live with their parents*
- *2 children are unaccompanied asylum-seeking children.*

- In the last 12 months:
  - *there have been 30 adoptions*
  - *19 children became subjects of special guardianship orders*
  - *189 children ceased to be looked after of whom 12 (6.3%) returned to live with their parents;*

Other Ofsted inspections

- The local authority operates no children's homes.
- The previous inspection of Southampton's safeguarding and looked after children's service was in April 2012. The local authority was judged to be adequate.

Other information about this area

- The Director of People provides the statutory function of Director of Children's Services. The current post holder has been in post since April 2013.
- The chair of the LSCB has been in post since November 2013.

[4] These are residential special schools that look after children for fewer than 295 days.

Inspection judgements about the local authority

Key Judgement	Judgement Grade
The experiences and progress of children who need help and protection	Requires Improvement

Summary

The timeliness of decisions and assessments has improved from a low base but is not yet consistently good. Records of decisions, including records of strategy discussions, are not always clear or detailed and do not often enough involve agencies other than the police and social care. Although the quality of assessments has improved, they do not routinely capture the life experience of the child, and recording is not always purposeful. Child protection planning is effective in the majority of cases, but lacks effective contingency planning. Few older children participate in child protection conferences. There is good awareness of and responses to the risks of child sexual exploitation, but monitoring of children who go missing from home and care is not robust enough. Improved information sharing helps to ensure that children and young people who are, or who are likely to be, at risk of harm, are identified swiftly; where necessary, robust and prompt action is taken to make sure they are safe. Early help services are available to children and families including well-coordinated, multi-agency support where this is required. Thresholds are well understood and operate effectively in most cases. Children in need of protection are listened to and heard by social workers, who understand the importance of building effective relationships with them.

68. Children and young people and their families can access help and support through a wide range of early help services, including children's centres. Many examples were seen of effective early help for children and young people preventing escalation to statutory services. As part of the City's Early Intervention Strategy, integrated early help teams were established in March 2014. These teams are therefore at an early stage of their development but their work seen was of good quality.

69. Services are well tailored to the individual needs of families and focused on improving outcomes for children. The newly formed, multiagency early help teams ('pre-birth to four years' and '5-19 years') undertake all universal help assessments at level two. This has resulted in a significant rise in the volume of Universal Help Assessments (UHA) (which have replaced the common assessment framework in Southampton) indicating that more children are being supported at an early stage. The Families Matter service is well designed and has made significant progress in achieving its targets in improving outcomes for children living in troubled families.

70. Thresholds for children and young people needing help and protection are understood by partners. The majority of referrals are of good quality, contain comprehensive detail and consider the impact on children. Partner agencies spoke positively and confidently about the MASH, to which there has been a recent increase in referrals. The likely reasons for this are well understood by managers but it has put additional pressure on services and at the time of the inspection was impacting on performance in terms of timeliness of response. No children were found to have been left at risk as a result of these pressures and clear plans are in place to manage the increased demand. Overall, performance data demonstrates that implementation of the MASH has significantly improved the timeliness of decision making at the point of contact and referral.

71. The range and work of agencies in the MASH, including health, housing, independent domestic abuse advisors (IDVAs) and police officers mean that it is an effective arena for sharing information to inform decision making. Decisions about thresholds of need and risk are made by qualified and experienced social workers, and in most cases are appropriate and demonstrate effective risk evaluation. Poor information sharing and decision making, which missed opportunities to safeguard children, were strong features of learning from recent serious case reviews, and practice within the MASH demonstrates how that learning has been used to improve practice. In a sample of 21 cases reviewed by inspectors, three (14%) were closed inappropriately at the contact stage when they should have progressed to a referral. In these cases; there was a failure to fully evaluate the presenting information to inform the decisions made. This led to a delay in children being assessed, but did not leave them at risk of significant harm.

72. Where child protection concerns are referred, and are the subject of a strategy discussion, this generally takes place between police and a social care team manager. Other agencies are rarely involved and, as a result, their views and information may not be fully considered in decision-making about the future actions required to investigate concerns. The decision at strategy discussions about the need for Section 47 enquiries was appropriate in the majority of cases, the record of the strategy discussion, grounds for decision, identified actions and timescales were not clearly recorded. Consequently there is a lack of clarity as to what actions should be undertaken, by whom, and by when.

73. When face-to-face strategy meetings are held they are promptly convened and well-attended by relevant agencies. Participants consider what action is required to safeguard and promote the welfare of the child and plan how the child protection enquiry will be undertaken, and who will carry out the agreed actions and when. More cases would benefit from such an approach, rather than discussions over the telephone. This was a learning point from recently published Serious Case Reviews and, whilst progress has been made, good practice is not sufficiently well established in this area.

74. Child protection conferences (CPCs) are timely; with good attendance and reports by partner agencies. Social workers' written reports are provided in advance, and in the large majority of cases these are shared with parents prior to the conference. Conferences are well recorded and develop outline protection plans which address the presenting risks. Inspectors observed the 'Strengthening Families' model being used well with parents, who were encouraged and enabled to contribute their views. A recent evaluation of the model has been positive, with parents stating that seeing the problems written on boards assisted their understanding of what needs to change.

75. Emotional abuse features in around 78% of children with child protection plans, neglect in 49%, physical abuse in 48%, and sexual abuse in 6%. This is broadly in line with national figures. Domestic abuse is a factor in 80% of child protection plans and reflects above average levels of domestic abuse prevalent in this local authority area. Over use of multiple categories can make it more difficult to focus on key areas of risk but this was not evident in the practice seen. Assessments and plans showed a good understanding of needs arising from different categories of abuse.

76. Child protection plans are regularly updated, at well attended core group meetings where actions are monitored, reviewed and if necessary changed. Visiting frequency is routinely recorded in each plan but contingency planning is not. Parents are therefore not fully aware of the consequences should the risks not reduce. In a minority of cases, the required actions are documented in a style that is both too general and unnecessarily long. This makes it difficult for parents and professionals to use the plan effectively to ensure that the risk of harm is reducing for children. In a small minority of cases involving neglect and emotional abuse, there was insufficient rigour and challenge by independent chairs in reviewing progress and assessing whether alternative action was required. As a consequence, in a small number of cases, ineffective plans were being pursued for too long.

77. Children of all ages subject to child protection and children in need plans, have access to a wide range of services to help support them. Many examples were seen of interventions resulting in good outcomes, including supporting real improvements in good and protective parenting, and abusive carers being permanently removed. Older children have access to an advocacy service to support them at child protection conferences and core groups. However, levels of attendance by children and young people are low. The local authority is aware of this, and has recently implemented an approach where this service is automatically provided for children and young people (rather than them having to 'opt in') in order to increase the number of children and young people attending CPCs.

78. Children who need assessment and support are seen and spoken to alone by social workers when it is appropriate to do so. Social workers are persistent in their attempts to work with children, young people and parents who are hard to engage, and practitioners recognised the different strategies used by some parents to avoid engagement. The large majority of single assessments are timely, take into account history and describe children's and families' circumstances. They demonstrate a good understanding of the potential impact for children of domestic abuse and long term neglect. However, the majority do not adequately convey a clear sense of the child's life experience. Social workers know the children and young people they are working with well and are able to speak about their needs, wishes and feelings, but this is not always documented or evidenced in case recording. Recording is generally up to date but the majority of case records lack sufficient detail and purpose.

79. Since January 2014 management oversight has become more robust and the quality of assessments and plans has improved. This has helped to reduce the incidence of drift and delay in assessment and care planning which was a common feature of work prior to 2014, as identified by a number of serious case reviews.

80. Disabled children have access to a good range of support services. The Jigsaw service provides comprehensive, integrated and effective support for children with complex health needs and moderate or more significant learning needs. Assessments are detailed, resulting in comprehensive plans to bring about improvements.

81. Inspectors saw several examples of children and families receiving services that are responsive to issues of language, culture and ethnicity. This includes good use of interpreters and translation. Where needs arising from diversity are identified they are usually well addressed, but where such needs present less clearly, assessments did not consistently explore or analyse them.

82. The out of hour's social work service is provided by an experienced team of social workers. The communication between the out of hours and day time services is robust, ensuring that families receive a seamless service and all emergency activity is followed up promptly.

83. Privately fostered children and young people and their carer's receive a responsive service led by a dedicated private fostering social worker. Placements are well supported, with regular visits, promoting stability and positive outcomes for children, in particular those attending language schools. Good attention is given to their family circumstances, religious and cultural needs. A series of events, including radio interviews, have been effective in raising awareness about private fostering across the city. At the time of the inspection there were 24 children privately fostered.

84. Southampton has exceptionally high levels of domestic abuse, and this is a factor in 80% of child protection cases and 51% of children in need cases. Social workers demonstrate good awareness of the impact on children of domestic abuse and have access to a range of specialist advice and services to support children and families. Multi agency risk assessment conferences (MARAC) are established, and are well attended by partner agencies, with good information sharing to plan effective action to reduce risk. Referrals to MARAC are appropriate and timely, with 620 cases considered during 2013-14 relating to 878 children. Work is undertaken in high risk domestic abuse situations with good access to independent domestic abuse advisors (IDVA) including a young person's IDVA who works with young people under 18. The IDVA service has a high level of engagement, currently working with 63% (303) of all referrals.

85. Learning from SCRs has resulted in the creation of PIPPA (prevention, intervention and public protection alliance) a single point of contact for professionals, in order to increase the number of non-police referrals to MARAC and improve identification of risk across Southampton. As a result, there has been a 12% increase of non-police referrals to MARAC. The introduction of a PIPPA HUB has provided a direct link to maternity services and the emergency department, which has resulted in increased referrals to both MARAC and the IDVA service from health professionals.

86. Adult substance misuse and mental health issues feature significantly in a number of child protection cases, although precise prevalence figures are not known. Inspectors saw strong engagement with and by these services in safeguarding children, including good quality, timely referrals and good information sharing and joint working with children in need of protection. This indicates that lessons from serious case reviews have led to improved practice.

87. Arrangements to address child sexual exploitation (CSE) are in place. A dedicated CSE social worker, co-located with the police, undertakes direct work, assessments and monitoring of children and young people at risk of child sexual exploitation. This specialist worker has supported 23 children since April 2014. A number of investigations remain ongoing and multi-agency working and disruption strategies are leading to young people being protected and perpetrators being prosecuted.

88. Arrangements for identifying and tracking children and young people missing from home and care are under-developed with patterns and trends yet to be identified. Senior managers are regularly updated in order to monitor high risk cases. Independent return interviews with children and young people are undertaken by 'Miss U', a commissioned service. During 2013-14, 42 such return interviews took place. However, the child's social worker is not always informed that these have taken place or the information gathered which might inform the child's future safety. Information sharing between children's social care and the police is more systematic and cases regarded as high risk are actively monitored. However, the weaknesses in data collection, analysis and information sharing inhibits the development of safe care strategies for individual and groups of children and young people and means that risks may not be identified and patterns of behaviours and trends are not tracked.

89. Currently, 188 young people are registered as home educated. The local authority maintains a list of children and young people who are electively home educated (EHE), but does not monitor the quality of home education annually, although it is establishing additional risk assessment arrangements for EHE children as part of its transformation arrangements. Procedures are in place for establishing the identities of children who are not registered at school, and for confirming forwarding destinations of those who leave school. Good use is made of a range of data from different sources and schools have guidance on the actions to take following withdrawal of a child from school. The overwhelming majority of children potentially missing from school are successfully tracked and located. In the 2013-14 academic year, six children were not located.

90. All young people who present as homeless are referred to the Southampton City Council homeless team for a housing assessment. As a result 62 young people aged 16 and 17 were prevented from becoming homeless in 2013-14. At the time of the inspection there were no children registered as being homeless. There is good access to timely mediation and, if this fails, the provision of emergency accommodation, a range of supportive accommodation and multi-agency support is available. Very few young people in this group are brought into care, only one in the past six months. The assessments of young people presenting as homeless do not record any evaluation of whether these young people would benefit from becoming looked after, or present this as a positive option to young people.

91. Allegations against professionals are managed effectively by the local authority designated officer (LADO). Allegations are dealt with in a timely fashion, with good attendance by appropriate agencies at strategy meetings. Clear evidence was seen of the outcomes of these processes leading to children being better protected.

Key Judgement	Judgement Grade
The experiences and progress of children looked after and achieving permanence	Requires Improvement

Summary

Most children, who cannot live safely within their own immediate family, benefit from better quality assessments, appropriate thresholds and effective decision-making processes. The length of care proceedings is reducing, enabling plans for permanent placements to progress in a more timely way, but a small number of children are still waiting too long without a secure home. For some children, frequent changes in social worker have led to delay in progressing their plans. Children are not sufficiently supported to access advocacy or independent visitor services. Although some good quality care plans were seen, others did not address children's emotional or contact needs sufficiently, and not all children and young people have the opportunity to access life story work. Looked after reviews are not always timely or sufficiently challenging. Foster carers provide good quality care for looked after children and placement stability is good. Overall, looked after children's educational and health outcomes are improving and youth offending rates are reducing. Although children who go missing from care receive an independent return home interview, information from this interview is not shared and used to promote the young person's safety. Arrangements to consult with looked after children are underdeveloped.

Some children waiting for adoption have experienced delay in securing a permanent family and, although leaders are taking action, there are a small number of children for whom permanency has not yet been secured. Adoption performance against the adoption scorecard is not good but steady progress is being made to bring the City in line with local and national comparators. Although family finding is improving the demand for adopters still exceeds the number of available families.

For many care leavers, the local authority's services do not prepare them adequately for adulthood nor support them to achieve their potential. The numbers of care leavers in education, employment or training is well below national averages and very few successfully attend higher education. Housing options are too limited, and as a result, some care leavers are living in unsuitable accommodation. These poor and unacceptable outcomes mean that services to support care leavers are inadequate.

92. Southampton has experienced a significant increase in the number of children they look after in recent years, rising from 286 in 2007 to 539 in July 2014. The proportion of children looked after per head of child population is now significantly above the national average. This reflects a history of ineffective preventative services and poor care planning. As a result, children have not received effective support early enough to prevent the need to become looked after, and other young people have remained looked after longer than they need to. The local authority has responded by embarking on an ambitious three year transformation programme, with a specific focus on strengthening early intervention and improving care planning.

93. Parents can now access a good range of services, including intensive support if needed, to support their parenting and help them to make the necessary changes to care properly for their children. Improvements can be seen in the way that professionals work effectively together to assess children and young people's needs and identify risk, which means that the right decisions are now made to look after children and young people at the right time. Appropriate thresholds are applied and no cases were seen of children entering care inappropriately. Unless an emergency admission is needed, legal planning meetings are chaired by senior managers who ensure that pre-proceedings work is undertaken before decisions are made to accommodate children. This provides an additional level of scrutiny and ensures that social workers have considered all appropriate alternatives to care.

94. The Public Law Outline (PLO) is being used effectively to ensure that children's safety and welfare is secured and that consideration of future permanency is embedded in plans for all children. Letters before proceedings are well written and clearly explain to parents the assessments that will take place and what needs to change, timescales, to prevent the need for legal intervention.

95. Children and young people are benefiting from more timely court proceedings which are reducing the period that children have to wait before having some certainty introduced into their lives. In cases initiated since May 2013, government targets of 26 weeks are not being met, but the length of proceedings has reduced from 41 to 34 weeks and continues on a positively downward trajectory. Currently 11 cases are exceeding the 26 week target and robust tracking by senior managers has ensured that the reason for delays are understood and action plans in place to monitor progress closely and expedite final hearings in each case at the earliest opportunity.

96. There has been an improvement in the quality of applications before the court, and statements of evidence are more focused and analytical. When family members are identified as potential alternative carers, viability assessments are undertaken promptly by the fostering service. This means that children and young people's permanent placement needs are secured within their families at the earliest opportunity.

97. Legal planning meetings reflect improving practice in ensuring that permanence, including special guardianship, is considered for all children at the point of becoming looked after. Financial and practical support arrangements for special guardianship have not been clearly established in all cases, and this has deterred or delayed some carers considering this course of action. This has caused delay in achieving legal permanency for children and young people who are in otherwise long-term and secure placements. The local authority recognises that this is a gap and has begun to take positive action to review its policy and practice.

98. Capacity to care and 'sibling together or apart assessments' are increasingly evidenced based. This has been supported through input from the Behaviour Resource Service (BRS). This work provides clinical and therapeutic consultation to assist social workers in considering the strength and importance of children's attachments to significant people and the capacity of their parents and carers to change. Its quality has increased the court's confidence in care proceeding applications and has resulted in a reduction in the use of independent expert witnesses in care proceedings. This has benefited children by enabling proceedings to be concluded in a more timely way, thereby reducing delay in confirming future plans for them.

99. When children need to be looked after, the preference is to provide accommodation with 'in-house' foster placements. Where this is not possible, strong commissioning arrangements are used to identify placements through Independent Fostering Agencies (IFAs). Once children and young people are placed, there is no pressure to bring children and young people back in-house if the placement meets their needs. There are a number of children and young people with long-terms plans in Independent Fostering Agencies (IFAs) where placements are providing stability and supporting positive transitions into adulthood. Parents express a high degree of satisfaction with their children's placements and value the support their children receive.

100. A few children have been looked after for too long because of delays in achieving their permanency plans. Senior managers have recently scrutinised all looked after children's cases and have ensured each child has an action plan with clear timescales for securing legal permanence. It is too soon however to see any impact of these plans.

101. Children are only removed from home when there is clear evidence that parents cannot change or adequately meet their needs in the long term. As a result, relatively few children return to live with their parents once they have been subject to legal intervention, as it has been established that permanence can only be achieved for them outside their immediate family. Those who do return to their parents' care are subject to sound risk assessment and support packages.

102. The vast majority of children live in long-term stable placements. Overall placement stability is good, with few (10%) children experiencing more than 3 moves in 12 months which is lower than the national average of 11%. Foster carers are well trained and well supported and recruitment and retention rates are good. BRS provides therapeutic support to foster carers to help them understand the complexities of children and young people's emotional needs and experiences and how to respond to challenging behaviour. The rate of fostering placement breakdown is therefore low, with 27 unplanned moves recorded in over 500 placements made in the past 12 months. Children and young people's achievements are regularly celebrated, and foster carers provide good opportunities for young people to experience leisure, cultural, sport and social activity. Carers are given delegated authority so that they can appropriately make decisions about children staying with friends and accessing leisure and social activities, although not all foster carers understand this well enough.

103. All looked after children and young people are allocated to qualified social workers although until recently many have experienced changes in social worker which has affected workers' ability to get to know children and young people well and develop a good understanding of their history and experiences. This is beginning to improve with more than 80% of social workers now in post for more than one year.

104. Statutory visits are mostly timely, and case file evidence demonstrates that social workers are seeing children alone where appropriate. However, they do not always evidence that visits to children have a purpose or how the visit has contributed to progress against the child's plan. Direct work with children is not well evidenced, but where it is undertaken children's wishes and feelings are clearly recorded. Life story work is underdeveloped and is not always appropriately prioritised. Therapeutic social workers from the BRS contribute to more complex life story work, but not all children and young people are supported to help them make sense of what has happened in their lives and to use this knowledge to help understanding their future plans.

105. Children and young people are not supported sufficiently to access an advocate or make a complaint. Access to an Independent Visitor is also limited, with a target of just six children to be matched this year. This target is not based by a clear needs assessment or analysis of the looked after population of 223 children and young people who are over 10 years. Despite a contract with 'No Limits', an independent provider of advocacy services, only one looked after young person has been referred to the service in the past 12 months and only two complaints from children and young people have been received in the same period. Not all looked after young people seen during the inspection knew that they could access an independent advocate or independent visitor.

106. Most looked after children and young people have a recorded and up to date care plan, but not all children's plans sufficiently address their emotional needs and family contact requirements particularly when siblings have a different plan. Expectations of carers and professionals are not defined, and it is not always clear how objectives will be achieved and what support is to be provided. The views of children, young people and their parents are not well evidenced, which means it is difficult to see how much they have influenced their plan. In some plans good attention was given to needs arising from disability, culture or ethnicity, but in a significant minority these were not clearly addressed.

107. Placement choice and quality means that most children live with their brothers and sisters where this is in their best interests, even if they are part of a large family. In most cases where appropriate, contact with brothers, sisters and family members is promoted, although this is not always reflected in written care plans. The current supervised contact service is under significant pressure due to the increasing volume of activity in the looked after system which has also seen a rise in the overall number of children looked after. This means that children and young people do not always receive continuity of supervisor or arrangements which is not in their best interests. Senior managers are aware of the capacity issues and have responded in the interim with additional resources. A review of the service is ongoing.

108. Due to capacity issues in the Independent Reviewing Officer service (IRO) children and young people are not always seen before their review by the IRO and rarely visited between reviews. The timeliness of reviews has decreased from 71% to 62% in the last quarter, and case examples were seen by inspectors of reviews being delayed or cancelled when this was not in the child's best interests. Some good examples of child centred reviews were seen, but in a minority of reviews, plans were not sufficiently tested and some previous actions were not followed up. IRO absence and turnover has also meant that a significant minority of children have not had continuity of IRO and the distribution of review records has been delayed.

109. The experience of children living out of area in residential placements is positive. Children and young people are in placements which mainly or fully meet their needs, including their education and health needs. Placement quality and safety are regularly considered and monitored. Providers commented that homes were not routinely visited by social workers before placement. The information they received prior to placement was not always comprehensive, but was sufficient to determine whether they could meet the child's needs. Information sharing post-placement was timely and reliable, with social workers responding to requests for information. Young people spoken to during the inspection reported positive relationships with their social workers and that social workers visit regularly. One young person told the inspector this made him feel safe.

110. A small minority of children's health assessments are not completed on time due to insufficient designated nurse capacity and a lack of sufficiently trained designated doctors. As a result, planning to meet these children's health needs is delayed. The integrated commissioning unit has instigated robust action to manage the backlog and is on target to complete this work by August 2014. Where health assessments are undertaken, they are robust and analytical and ensure that the health needs of children and young people are prioritised. Good multi-agency health plans help meet the needs of disabled children and children with complex health needs. BRS provides therapeutic support for children suffering from trauma and for foster carers who require support to understand children's emotional needs and how to respond to them. One looked after child told the inspector she likes going to BRS but does not like its name as her friends think she has problems because she is going to the "behaviour place".

111. Children and young people are supported well to make good progress in their learning. 78% of pupils attend good or better schools and the virtual school is increasingly effective in securing such places. Only four children are in inadequate schools and each child has an appropriate action plan in place. The virtual school are monitoring these pupils and pupil premium funding is being used to provide support. Eleven young people were following part-time time tables at the end of the summer term. Plans are in place to improve their engagement although the hours of tuition for four young people are low, (between five and eight hours per week) which will make planned progression to college challenging.

112. Children mostly make good progress in their early years and at KS1 attainment is in line with children looked after nationally for reading and above national average for writing and maths. At KS2 attainment is in line with looked after children nationally. In 2012-13 all made expected progress in maths and reading and most in writing. Despite high levels of special educational needs at KS4 almost half (44%), achieved 5 GCSE grades A*-C in 2012-13. This contributed to a significant closing of the gap in attainment between looked after and non-looked after children. Attainment is in line with young people looked after nationally but not enough are achieving qualifications in English and maths. There are no significant differences in outcomes between looked after children placed within or outside the city.

113. Overall, persistent absence levels are similar to the national and similar area averages. Only one pupil was permanently excluded over the past five years. Managed moves and targeted support have been used well. Levels of fixed term exclusions have reduced significantly, although a rate of 14% in 2012-13 was above the national average of 11%.

114. Attendance is monitored by the virtual school, but the progress information it holds is limited and impedes intervention. An electronic system has been established, but its use is not yet embedded. Personal Education Plans (PEPs) provide a good overview of health and emotional well-being and they consistently support and encourage participation in out of school activities. Overall however, targets for driving up attainment are often too general, and over half of PEPs require improvement. The virtual school is not sufficiently involved in PEP meetings, particularly with secondary aged pupils, to drive up standards and to ensure that pupil premium funding is used to best effect.

115. Children and young people benefit from the support of Educational Literacy Support Assistants (ELSAs), who are trained to deliver low level emotional interventions in school to every looked after child. They report directly to educational psychologists, who fast track children into BRS or CAMHS if they require more intensive therapeutic interventions.

116. All reports of children and young people who go missing from care are scrutinised by the police, and young people who may be vulnerable to sexual exploitation are referred to the Missing, Exploited and Trafficked Group (MET). 'Safe and well' visits are undertaken by police when a child returns to their placement. In addition, independent 'return home' interviews are undertaken via a contract with a voluntary sector provider, but information sharing from these interviews is not effective. Social workers and managers do not receive a copy of the interview nor confirmation that the visit has taken place, and therefore cannot be satisfied that return interviews are being undertaken. They are unable to analyse patterns of behaviour, trends or risk in order to develop safe care strategies or assess whether the young person found the intervention useful. Local authority managers recognise these deficits and are reviewing their commissioning and contract monitoring arrangements for this service.

117. Procedures for diverting young people from offending are beginning to have an impact. First time entrants to the judicial system have reduced by 18%, compared with the previous year. Custodial sentences have reduced from 49 in 2011/12 to 18 for 2013-14. Persistent offending is also decreasing together with the numbers of offences committed by the most persistent offenders. There is evidence of good multi agency working to support children and young people misusing substances and alcohol. Well-coordinated interventions from specialist young people's substance misuse services ensure that they are triaged quickly and that support is provided for as long as needed.

118. The Young People in Care Council (YPIC) is in its infancy and currently consists of ten young people age 17 to 19. Members of the YPIC are enthusiastic about their role and have strong support from the lead member of the local authority and senior managers. The young people have made a positive start, and have recently held a celebration event for looked after children and care leavers, and they are supporting younger looked after children to participate in leisure activities. Although they have some support to develop the YPIC, they require dedicated input from a participation officer to help structure and develop the service and plan how they can consult with other children and young people across the service and support their engagement.

The graded judgement for adoption performance is that it is requires improvement

119. The local authority transformation plan recognises that the adoption service was poorly performing. There was drift and delay in achieving adoption for many children, reviews of plans were not challenging or rigorous enough, management oversight and scrutiny was poor and adopters did not receive a timely service. Robust action has been taken to address these deficits, which has led to improved performance, although this is not yet good. In the last twelve months, new leaders have established a performance culture and introduced trackers that mark the child's journey through the PLO process and the family finding stage of the adoption system. Greater management oversight is helping to improve timescales. As a result, adoption plans are now commencing at an earlier age and progressing more quickly through the adoption process.

120. However, performance measured against the 2012-13 adoption scorecard is not good. It took, on average, 691 days for a child entering care to progress to live with their adoptive family. This performance is 83 days longer than the performance threshold and above the national average of 647 days. The time taken between the courts deciding that adoption is in the best interests of a child and this authority deciding on a match is 139 days, and whilst this met the previous performance threshold performance is not improving. The trajectory of both these performance measures is heading in the wrong direction and managers in this authority do not expect to meet the thresholds when the next scorecard is published. This is because of a number of historical cases that impact performance.

121. Children are currently progressing through the adoption system more quickly than they did previously. 82% of children placed for adoption have been placed in the last 12 months. 6 children were matched within three months of the local authority receiving court authority to do so and a further 21 were matched within 6 months.

122. 30 children were adopted in 2013-14 and 11 have been adopted since April 2014. The local authority has had significant success in placing older children and sibling groups, who are considered harder to place. Whilst this is good for children it does adversely affect the scorecard performance. Seven percent of adoptions were of children aged five or older compared to the England Average of four percent.

123. Adoption is appropriately considered for all children who are unable to go home to their birth family and the authority is appropriately ambitious in aiming for adoption for children where this is in their best interests. Overall a slightly higher percentage of looked after children are adopted in Southampton than for similar areas (6% as compared with 5%). For a small number of children, however, this ambition has not led to them being adopted and they have waited too long for permanence and for suitable alternatives to be considered. Between 2009 and 2012 no children had their permanence plans changed from adoption. This historic practice means that there are a number of children for whom adoption has not been achieved but remains the plan. At the time of the inspection, 17 children had been waiting two years or more to be placed for adoption. The local authority has been actively reviewing cases where children have been waiting too long. This has led to some plans being rescinded and permanence secured with existing foster carers.

124. There are no formal arrangements for concurrent planning or fostering for adoption although a number of children have been successfully adopted by their previous foster carers. Parallel planning is not evident in historic cases but is more evident recently which, combined with more effective use of PLO processes, is reducing delay.

125. Contact arrangements are carefully considered to make sure that these are in the best interests of children. Inspectors saw good examples of assessments that considered whether siblings should be separated or stay together, and the outcomes of these assessments are reflected in placement planning so that children are not separated unless this will meet their individual assessed needs.

126. The demand for adopters currently outstrips supply; the current number of children waiting for adoption is 46 while there is a pool of only eight approved adopters. The local authority intends to use its adoption reform grant to purchase adopters from Voluntary Adoption Agencies (VAAs) and local consortia to meet demand. Leaders feel assured that this will provide sufficient adopters, but this approach does not build ongoing capacity to increase the pool of locally available adopters. Plans for a marketing campaign and to strengthen internal recruitment are at an early stage of implementation.

127. When adopters do come forward they feel well supported, but have experienced delay. One adopter said 'my individual social worker was really supportive…but the process was frustrating and slow'. Another commented that 'apart from being a bit slow it's been really positive'. Once the assessment stage starts, progress is quicker. The local authority has improved its responsiveness to initial enquiries and new adopters are now progressing more swiftly through assessment and preparation processes in line with national standards.

128. A broad range of options are pursued for family finding, including activity days. A considered approach to matching means that there have been no adoption disruptions in the past two years. The authority has had significant recent success in placing nine children aged over six and six sibling groups that total 13 children. This is a reflection of the determination and commitment of the service.

129. Family finding and management tracking does not begin at the earliest possible point, i.e. from the point that adoption is being considered, but at the point the agency decision maker ratifies the plan for adoption. Inspectors also noted in some cases examples of a number of small delays which cumulatively amount to significant time lost in achieving adoption for individual children.

130. Life story work is not always completed in a timely fashion and Life Story books are of variable quality. This means that a minority of adopted children and their adopters are not helped to fully understand their early childhood experiences.

131. The quality of work being presented to the panel is described by the independent panel chair as 'improving', in both timeliness and quality. Some helpful training was given to panel members earlier in the year, but there are not clearly established arrangements for regular training and practice updates, which would strengthen the ability of the panel to quality assure and improve practice.

132. Adoption support packages are currently being given to 11 children. Adopters value the support provided by the BRS and at the time of the inspection no children were found to be waiting for adoption support to be provided. Some 89 children are supported with financial packages, and this is contributing to stable placements. All children being adopted have adoption support plans, but the majority seen by inspectors were formulaic and did not always clearly identify set out who will provide the support, its nature and in what timescale. Counselling is offered to birth parents, but when adopted adults request support it is not always provided quickly.

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

133. Services for care leavers are not preparing them adequately for adulthood or to fulfil their potential. The numbers of care leavers in education, employment or training is well below the national average and very few successfully attend higher education. Housing options are too limited and, as a result, a significant minority of care leavers are living in unsuitable accommodation. These poor and unacceptable outcomes mean that services to support care leavers are inadequate.

134. At the time of the inspection around 30% of care leavers were either not in contact or assessed as not living in suitable accommodation. This included a small number (three) in bed and breakfast accommodation. Bed and breakfast accommodation is not used routinely and only as a short term, last resort. Other young people were noted to be sharing informally with friends, in houses of multiple occupancy or in hostel type accommodation which did not meet their needs. In such cases considered by inspectors there was not always a clear risk assessment or a sufficiently robust monitoring arrangement in place. As a result of these deficits in suitable accommodation arrangements, the local authority cannot be assured that all care leavers feel safe and are safe.

135. Care leavers living in foster care are encouraged and supported to 'stay put' with their carers after they reach 18. Good support is also provided for care leavers to access and sustain tenancies in privately rented accommodation. The local authority is aware of the shortfalls in current provision and has taken steps to improve this by, for example, increased use of supported accommodation provided by the Next Steps service. Plans are in place, with partners, to fully review the local authority commissioning of accommodation services.

136. Although 103 looked after young people have been involved, in recent years, in projects to engage those who are Not in Education, Employment or Training (NEET) or at risk of being NEET, the proportions of young people in education, training or employment (ETE) in years 12, 13 and 14 are not improving. Currently too many young people do not benefit from these opportunities. (65% in year 12, 55% in year 13 and 36% in year 14 respectively). Few gain level 2 or level 3 qualifications and only three care leavers are at university. The authority has committed to providing apprenticeships for care leavers, with placements due to commence in the next month, but no care leavers are currently in an apprenticeship. Individual workers do strive hard to provide advice, support and guidance to care leavers, as does the local college. As a result, some care leavers do achieve well. However support is not systemic as the role of the virtual school formally ends at 16. This means that workers cannot readily access suitably specialist knowledge and advice. There are no management processes for tracking the placement and performance of care leavers, which inhibits resources and activity being focused on young people currently or at risk of becoming NEET.

137. Looked after young people are encouraged to remain looked after until they reach 18 and can access relevant support to develop independence and life skills. In most cases seen by inspectors, however, needs assessments and pathway planning had begun too late and lacked clear analysis and action planning. As a result, it was not effective in predicting and preventing difficulties and disengagement post 18.

138. This disengagement resulted in the local authority losing contact with more care leavers than its statistical neighbours. This means that the 35 young people that the local authority are no longer in touch with, are not able to benefit from the advice guidance and support from their corporate parent. Nearly all care leavers have a pathway plan and the majority of these are reasonably up to date. Most plans provided an overview of history and current position, but are not proactive in setting out plans to promote participation in education or address other presenting difficulties. The format for pathway plans has recently been reviewed in consultation with young people and is now both simpler and more action focused. This is being used to improve the quality and impact of pathway plans and the most recent examples were of a good quality.

139. Support for health needs and health advice for care leavers is too variable. Some examples were seen of good support being provided to meet sometimes complex mental health and therapeutic needs but this was not evident in all cases where it was needed. Access to sexual health advice and health promotion is not assured, and not all care leavers had received appropriate support to access and understand their health histories. Most had not been provided with clear information about their entitlements, right to complain or information on how to access an advocate.

140. Transition arrangements for care leavers who meet adult care services criteria are clear and effective, including those for disabled young people. The local authority has ambitious plans for further developing services for young adults.

141. Workers in the Pathway Team work hard to compensate for the deficits in services for care leavers. They are young person focused and work hard to engage and support young people although this is constrained by competing demands on their time and a lack of expert knowledge and support. Young people value the support offered by their social workers and personal advisers. Inspectors saw young people benefiting from this support and the consistent relationships they had developed. However, for many care leavers this support has not been sufficient to ensure good foundations or enable a successful transition into adulthood.

Key Judgement	Judgement Grade
Leadership, management and governance	Requires Improvement

Summary

Children's services in Southampton City have benefited from the appointment in April 2013 of a new Director of People who carries out the statutory functions of the Director of Children's Services (DCS). She is supported by a strengthened and increasingly permanent management team who share her ambition to effect sustainable improvements to services. The DCS, supported by corporate and political leaders, has led a robust analysis and critique of services. Based on this analysis, an ambitious improvement programme has been developed and implemented. This includes a transformation programme to restructure services and establish a new working culture in order to meet children's needs and reduce risks more effectively. An experienced, interim Head of Service is in place to support and drive the required improvements. This inspection found substantial evidence that this programme is beginning to have a positive impact in transforming practice, and that this is beginning to improve outcomes for vulnerable children in a number of key areas.

However, the leadership management and governance of the local authority is not yet good as, despite significant progress, there are elements of improvement needed, that are not yet in place. For example, services for care leavers are inadequate; strong corporate parenting is not embedded or demonstrating impact; tracking and risk management for children missing from home and care are not robust; performance management is an improving area of work but is not yet sufficiently focused on improving quality; and the quality and frequency of professional supervision are not sufficiently consistent. Although significant success has been achieved in reducing reliance on agency social workers, challenges remain in securing a sufficiently experienced, skilled and permanent workforce throughout the organisation. Political scrutiny arrangements have not been effectively applied to key areas of children's services.

142. The DCS acts as Director of People and this arrangement integrates management of children's and adult's services. An appropriate test of assurance was undertaken prior to introducing this arrangement and its recommendations were followed. The services considered by this inspection were a clear priority for the current DCS and inspectors saw consistent evidence of clear focus and leadership of these services.

143. There is effective, if not routinely recorded, communication between the Chief Executive, Lead Member, Leader of the Council, LSCB Chair, DCS and Head of Service that ensure priorities and current issues are effectively addressed. The Lead Member for Children's Services brings a good level of knowledge and experience of issues within children's services from his professional background, and the DCS commands the confidence of local leaders and partner agencies, including schools.

144. Appropriate structures are in place, including representation on the Health and Well-being Board and the Children's Trust. Effective strategic partnership working is further enhanced and delivered through strong professional relationships and the Transformation Board. Strong partnership working has supported the operation of an effective integrated commissioning unit and enabled the swift creation of Southampton's MASH and Early Intervention Teams. The Local Authority has supported and challenged the LSCB to improve its performance. The Chief Executive and DCS work effectively with the new independent LSCB Chair and welcome the Chair's independent challenge. However, regular and detailed scrutiny of children's services is not undertaken by either the Health Overview and Scrutiny Panel or the Oversight and Scrutiny Management Committee.

145. The Lead Member and senior managers have a strong understanding both of the needs of the local area and the extent to which current services are effective in meeting these. Substantial progress has been achieved in improving services and outcomes for vulnerable children in Southampton. Clear strategies are in place to further improve performance and practice.

146. Strategic commissioning arrangements within Southampton are strong. A jointly funded and managed Integrated Commissioning Unit leads on all aspects of commissioning for vulnerable and looked after children. Commissioners have a good understanding of the range of needs and priorities to be met and make good use of their pooled budget. The arrangements for the multi-agency resource panel are well advanced and a real strength, resulting in children quickly benefiting from additional specialist services when these are required to meet their needs.

147. The Joint Strategic Needs Assessment (JSNA) and sufficiency strategy are appropriately aligned. The JSNA is due for renewal, but does provide an overarching strategy for meeting the needs of children and families within Southampton. The sufficiency strategy is now effectively integrated within the joint commissioning strategy. This supports the local authority in meeting its duty to provide services that meet the needs of local children, young people and their families in need of help, care and protection; including provision of a range of appropriate placements for looked after children.

148. Leaders, both political and senior local authority managers, identify the need to improve the offer to looked after children, which is described as coming from a 'very low base'. The corporate parenting committee was re-launched in November 2013, as it was previously judged as being inconsistent and, at times, ineffective. It has, for example, failed to effectively champion the needs of care leavers who have been experiencing inadequate services for several years. The committee has identified a number of areas for improvement, including empowering foster carers to contribute more fully to PEPs and challenging the spend of the pupil premium; improving care leavers' understanding of their entitlements and access to a suitable range of accommodation; increasing children's access to advocacy; and ensuring that care leavers have access to apprenticeships and work experience opportunities within the City Council. However, these objectives remain mainly aspirational at the current time.

149. Performance management and the use of performance data is improving, with a good suite of performance information now available and being used. This is, however, an area acknowledged as requiring further improvement and embedding. For example, reliable performance information is now being produced, but this is not accompanied by a written, qualitative analysis and narrative to help all managers understand what the data is indicating and what might be the causes of performance deficits. Performance measures and case auditing does not yet focus sufficiently on evaluating the quality and effectiveness of services. Monthly case audits are now being undertaken by senior practitioners, team managers, service managers and principal officers. However only around half the target number of audits are being completed and the quality of these is too variable, with some lacking sufficient analysis. There is no system in place to gather the views of children and young people to inform the quality assurance of services. The local authority is also currently in the process of improving its action and improvement plans, so that they evaluate the extent to which intended outcomes for children have been achieved alongside whether actions have been completed or not.

150. The quality and frequency of formal case supervision and professional supervision is not of a sufficiently consistent standard. There are examples of good supervision records, but the large majority did not meet this standard. In the good supervision records, detailed case direction was provided, together with challenge and consideration of the worker's professional development and targets for the year; however, many records lacked evidence of reflective practice and challenge, and there is currently inconsistent practice in undertaking staff appraisal.

151. All workers spoken with rate highly the quality and availability of informal supervision; this includes discussion with both managers and team-colleagues. In one team, workers and their team manager have developed an effective and valued meeting called 'Team Rap' in which they provide each other with support through reflective case discussion. Managers are routinely recording their decisions using the management decision case notes. However, the quality of these records needs improving to ensure that the evidence base and rationale underpinning decision-making is clear in all cases.

152. The Lead Member, Chief Executive and DCS evidence a sound understanding of front line practice and performance issues across the service, which is gained through direct observation, casework scrutiny and performance information. This included participation in an insightful back-to-the-floor day when the Chief Executive, DCS and Principal Officers joined social workers in their work with children and families for a day during April this year. There is also positive evidence of senior leaders actively seeking learning and benchmarking opportunities from other local authorities to inform local improvement.

153. Senior managers have been successful in improving the reputation of the local authority with the Local Family Justice Board and Cafcass. Joint working is much improved in this area, and has led to reductions in timescales and delay in legal proceedings.

154. The local authority has achieved a swift transformation in its workforce, reducing the use of agency workers from around 47% to fewer than 10%. This has led to greater workforce stability and more consistency for children. Many of the new permanent social workers started as newly qualified, and they received good support and protection in this role. There has been an active and effective Assessed First Year in Employment (ASYE) programme over the past two years in Southampton and the authority have supported 50 newly qualified social workers through the programme. Of these, 80% (40) continue to be employed by the local authority.

155. Whilst a significant improvement has been achieved in staffing, and caseloads have been reduced, inspectors saw evidence of services still under workload pressure, most often due to staff absence or peaks in demand. There is little slack or flexibility within current capacity, which creates vulnerability for services in not being able to deliver to agreed standards. However, nearly all staff spoken to were positive about the changes achieved in Southampton and are enthusiastic and optimistic about the future.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement
The arrangements in place to evaluate the effectiveness of what is done by the local authority and board partners to safeguard and promote the welfare of children require improvement.

Summary of findings

The local safeguarding children board requires improvement because:

156. Its use of data to examine the performance of partner agencies is too recent to provide a comprehensive view of strengths and weaknesses in the system.

157. It has only recently begun to audit the practice of partner agencies and how they work together, and it is too soon to see whether this will bring sustained improvements.

158. It has not provided effective scrutiny of safeguarding arrangements for children who go missing or for girls at risk of genital mutilation.

159. The Board's annual reporting has not provided a rigorous and transparent assessment of the performance and effectiveness of local services.

160. The long term impact of the LSCB training programme in improving child protection and safeguarding has not been evaluated.

What does the LSCB need to improve

Areas for improvement

Data and performance management

161. Consolidate the use of management information from partner agencies and use it systematically to understand trends, quality and performance.

162. Ensure that the annual report of the Board provides a rigorous assessment of the quality of multi- disciplinary practice with children and their families and the impact of help, protection and care on their lives and futures.

Practice and policy

163. Develop protocols and guidance to support agencies in responding effectively to the risk of female genital mutilation.

164. Ensure that multi-agency arrangements for responding to children who go missing from home and care are well coordinated and that measures are in place to gather, share and analyse information, learn lessons and improve service effectiveness.

Understanding the quality of practice

165. Carry out regular case audits to evaluate the quality of practice in all partner agencies, including those providing early help.

166. Develop effective learning and improvement plans from case audits in order to improve frontline practice and management.

167. Ensure that the experiences and views of children and young people receiving help, protection and care are clearly understood by the Board, and improvement action is taken in response to their feedback.

The LSCB's strengths

168. Formal governance arrangements are clear, with regular reporting and accountability. They are supported by a strong working relationship between the independent Chair and senior leaders in partner agencies, particularly the Director of Children's Services. Lines of reporting and accountability between the independent Chair, the local authority's Chief Executive, Leader, Lead Member and DCS are defined and well understood.

169. The sub-group structure is coherent, with clear reporting and cross-group working. Priorities are aligned with those of other strategic groups, such as the Health and Wellbeing Board and the Community Safety Partnership, for example in relation to early help and domestic abuse.

170. Where necessary the independent Chair has been forthright in raising concerns with individual agencies about their contribution to the work of the LSCB. In one instance the chair challenged an agency about proposed staffing reductions that would have had an adverse impact on child protection and this led to a positive response.

171. Board partners have recognised the significant performance deficits that lie within the system and have embarked on an ambitious programme of change. The Board is helping to ensure the co-ordination of this work and is well engaged in monitoring its impact. There are early but significant signs of success, for example in the operation of the MASH, which has a high level of multi-agency input and cooperation.

172. Members report and demonstrate a culture of transparency and candidness within the Board. This is bringing an increased willingness by members to challenge others and to be challenged about the performance of their own agencies. Members report and welcome feeling under much closer scrutiny than previously about their own agencies' contribution and performance. Minutes of meetings provide evidence of challenge.

173. A published thresholds framework is well understood and applied by practitioners and front line managers. This is beginning to ensure that children, young people and their families receive help at the right level and can move between different levels of help when necessary.

174. There are sound arrangements for considering serious incidents and determining whether a serious case review (SCR) is needed. The Board has published three SCRs in the last year. These were all historical cases that should have been the subject of serious case reviews much earlier. The decisions not to progress to SCR were challenged by the incoming DCS last year and overturned by an interim LSCB chair. These SCRs were well coordinated to ensure that common themes were recognised and lessons learned. This has been impressive, and its impact is evident not only in the training that has followed and the awareness of staff in a range of agencies, but also in the design of the MASH and in the Board's priorities. For example, work is now underway to improve the multi-agency response to neglect.

175. The Board offers a comprehensive training and development programme that is responsive to emerging need. This has included the effective dissemination of lessons learnt from serious case reviews. Training events are well attended by partner agencies, including those in the voluntary sector.

Inspection judgement about the LSCB

176. The independent Chair has brought a culture of openness and transparency to the LSCB. Members are committed to working together to ensure that the quality of child protection and safeguarding work continues to improve. Its influence is beginning to be seen, for example, in the use of learning from serious case reviews. However, many of the positive developments are at too early a stage to see full impact or measure sustainability.

177. Safeguarding is a priority for all statutory LSCB members. This is seen in the level of participation in board and sub-group meetings and activities, contributions in cash and time to the LSCB, commitment to the MASH and participation in learning events. Members of the Board are senior leaders in their own agencies, with the authority to make decisions. The Board's budget is made up of proportionate contributions from partner agencies; it is agreed on a three year cycle and is sufficient for the Board's activities.

178. Regular monitoring and evaluation of the quality of multi-agency practice has only recently been established. Its effectiveness in enabling partners to understand and improve the quality of practice is not yet evident.

179. Until recently, the only auditing by the LSCB was done by an independent consultant. While this produced learning, the LSCB view is that the auditing did not engender sufficient recognition and response by the Board and its members. Multi-agency case auditing by LSCB member agencies is now underway, but is at an early stage of development. There is no evidence yet that lessons learned are contributing to practice improvements. A recently completed thematic audit of ten core groups was focused on compliance. While this was an understandable response to the need to know that core groups are taking place and attended in line with expectations, it has not provided learning about the quality and effectiveness of practice.

180. Prior to January 2014, performance reporting to the Board was not well structured or focussed. As a result performance was not effectively monitored. Formal reporting now takes place using an agreed data set and overseen by the Monitoring and Evaluation Group. This development is very recent and its effectiveness in supporting challenge and improvement is not yet evident.

181. There has been some activity to involve children and young people in board activity. As yet, this has not included seeking their voice to help the Board to understand the quality and effectiveness of services.

182. The long term impact of the Board's training and development activities on the quality of services and practice has not been evaluated.

183. The Child Death Overview panel covers four LSCBs, including Southampton. Some of the data it produces are not broken down by local authority area. This means that possible learning that is specific to Southampton is not identifiable.

184. The most recent annual report of the Board provides a more rounded picture of its activities than the previous version and includes reports about partner agencies. However, it is still largely descriptive. The lack of sustained data analysis and audit over the reporting year means that it does not present a thorough, systematic assessment of the quality and effectiveness of single and multi-agency practice. Its value as a tool to report on how effectively children are protected and their needs met is therefore limited.

What the inspection judgements mean

The local authority

An **outstanding** local authority leads highly effective services that contribute to significantly improved outcomes for children and young people who need help and protection and care. Their progress exceeds expectations and is sustained over time.

A **good** local authority leads effective services that help, protect and care for children and young people and those who are looked after and care leavers have their welfare safeguarded and promoted.

In a local authority that **requires improvement**, there are no widespread or serious failures that create or leave children being harmed or at risk of harm. The welfare of looked after children is safeguarded and promoted. Minimum requirements are in place, however, the authority is not yet delivering good protection, help and care for children, young people and families.

A local authority that is **inadequate** is providing services where there are widespread or serious failures that create or leave children being harmed or at risk of harm or result in children looked after or care leavers not having their welfare safeguarded and promoted.

The LSCB

An **outstanding** LSCB is highly influential in improving the care and protection of children. Their evaluation of performance is exceptional and helps the local authority and its partners to understand the difference that services make and where they need to improve. The LSCB creates and fosters an effective learning culture.

An LSCB that is **good** coordinates the activity of statutory partners and monitors the effectiveness of local arrangements. Multi-agency training in the protection and care of children is effective and evaluated regularly for impact. The LSCB provides robust and rigorous evaluation and analysis of local performance that identifies areas for improvement and influences the planning and delivery of high-quality services.

An LSCB **requires improvement** if it does not yet demonstrate the characteristics of good.

An LSCB that is **inadequate** does not demonstrate that it has effective arrangements in place and the required skills to discharge its statutory functions. It does not understand the experiences of children and young people locally and fails to identify where improvements can be made.

Information about this inspection

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

Inspectors considered the quality of work and the difference adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people who it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

Ofsted produces this report of the inspection of local authority functions and the review of the local safeguarding children board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

The inspection team consisted of seven of Her Majesty's Inspectors (HMI) from Ofsted.

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