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.

The inspection team

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