Southend-on-Sea

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: 25 April to 19 May 2016

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Children's services in Southend-on-Sea require improvement to be good		
1. Children who need help and protection		Requires improvement
2. Children looked after and achieving permanence		Requires improvement
	2.1 Adoption performance	Good
	2.2 Experiences and progress of care leavers	Good
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 Inspections Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

Executive summary

Children's services in Southend-on-Sea require improvement to be good. Some services are well led and provide good-quality, effective support for children and young people, and ensure positive outcomes as a result. However, the pace of change in areas where improvement is needed has been too slow and, overall, there has been a decline in the quality of services since the last inspection in 2012.

The local authority and its partners have undertaken considerable work to develop and bring together early intervention services. A coherent early help offer is effective in supporting families to make the changes needed to ensure that their children's needs are met. A successful funding bid has supported the authority to develop an ambitious programme, 'Better Start', with the aim of transforming the delivery of early childhood services. Primary health services are fully engaged in the development of this programme, which has the potential to make a significant difference to vulnerable children and their families. However, at the time of the inspection, it not been in place long enough to have a significant impact.

Most concerns that are referred to the local authority receive an appropriate response. However, in a minority of cases, insufficiently thorough initial checks, and inconsistent information sharing and assessments have resulted in children not receiving the right services as soon as they should. Some are referred and assessed too many times, or their cases are stepped down to early help services prematurely, before intervention has been fully effective. Children are seen and their immediate safety is assured. However, enquiries are not always completed quickly enough and this delays multi-agency planning, for some children. A gap in data has made it more difficult for managers to monitor the progress of child protection work accurately. The authority took action to address this during the inspection.

A very small number of children who have recently become looked after had remained longer than they should in harmful situations because of delays in progressing plans for them, although the authority was taking steps to manage the risk for them during this time. These children's circumstances were complex, and becoming looked after resulted in them being safe.

Once looked after, children benefit from positive placements that meet their needs, in most cases. Further work is needed to strengthen support for their educational achievement. The role of the virtual school is developing, with oversight of children's progress strengthening with better use of data. However, the quality of personal education plans remains underdeveloped. The authority has not done enough to promote the participation of children and young people in service development, and to strengthen scrutiny by elected members and corporate parenting. Plans for a small number of children who are living at home with parents under care orders have drifted, with not enough consideration being given to discharging orders or making alternative plans if the arrangement is not felt to be sufficiently robust for this to be achieved.

Social workers are not spending enough time with children. Nearly half of the children supported by social workers are not visited in line with their plans. Insufficient direct work with children and their families reduces the effectiveness of the service in improving children's lives.

Work to secure children's lives through adoption and services for care leavers are areas of significant strength in this local authority. A wide range of children are successfully adopted. These include those for whom it is often harder to find families, such as older children or those with disabilities. Care leavers are enthusiastic in their praise of the support provided to them. They feel that their workers know them well, and that they make successful transitions to adult life. Social workers and personal advisors have succeeded in remaining in touch with virtually all care leavers, ensuring that they can get help if they need it.

The social care workforce is stable. Few social workers leave the authority and most moves are internal, resulting from promotion or transfers between teams. Supervision arrangements for social workers have been revised to separate supervision on case work from discussions about workers' professional development. This has been positive for social workers, who report feeling well supported by managers. However, there is a need to strengthen the challenge that managers provide to ensure that social workers are driving plans for all children forward effectively.

The local authority and its partners have strengthened oversight and direction at strategic level in response to child sexual exploitation, children who go missing and other vulnerabilities, such as female genital mutilation and the risk of radicalisation. Further progress is needed to ensure that this translates consistently to better practice in frontline services. In some areas, such as the implementation of Channel arrangements, children and their families receive a well-coordinated, effective service. Further work is required to ensure that intervention in individual cases involving children at risk of sexual exploitation and those discussed at multi-agency risk assessment conferences is consistently effective in improving their circumstances.

Most of the shortfalls identified during the inspection were already known to the local authority. It has an appropriate performance management framework in place. The local authority regularly audits its own work and it has been supported by an external review of services. However, the pace of change in tackling the shortfalls that these checks have highlighted has been too slow.

In those parts of the service where practice is better, such as fostering, adoption and care leaver support, managers demonstrate stronger oversight, resulting in the provision of effective help for children and young people.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority does not operate any children's homes.
- The last inspection of the local authority's safeguarding arrangements was in June 2012. The local authority was judged to be good.
- The last inspection of the local authority's services for looked after children was in June 2012. The local authority was judged to be good.

Local leadership

- The director of children's services (DCS) has been in post since March 2013.
- The DCS is also responsible for adults' services, procurement and housing.
- The chair of the LSCB has been in post since March 2006.

Children living in this area

- Approximately 38,216 children and young people under the age of 18 years live in Southend-on-Sea. This is 21.5% of the total population in the area.
- Approximately 18.8% of the local authority's children are living in poverty (as at August 2013).
- The proportion of children entitled to free school meals:
    - in primary schools is 15.4% (the national average is 15.6%)
    - in secondary schools is 9.8% (the national average is 13.9%).
- Children and young people from minority ethnic groups account for 22.9% of all children attending Southend schools, compared with 22% in the country as a whole.
- The largest minority ethnic groups of children and young people in Southend's schools are mixed and Asian.
- The proportion of children and young people with English as an additional language:
    - in primary schools is 13.3% (the national average is 19.4%)
    - in secondary schools is 12.7% (the national average is 15%).

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

Child protection in this area

- At 12 May 2016, 999 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 1,024 at 31 March 2015.
- At 12 May 2016, 183 children and young people were the subject of a child protection plan. This is similar to the figure of 184 at 31 March 2015.
- At 12 May 2016, five children lived in a privately arranged fostering placement. This is a reduction from nine at 31 March 2015.
- Since the last inspection, three serious incident notifications have been submitted to Ofsted, and one serious case review has been completed or is ongoing at the time of the inspection.

Children looked after in this area

- At 12 May 2016, 263 children were being looked after by the local authority (a rate of 68.8 per 10,000 children). This is an increase from 230 (60 per 10,000 children) at 31 March 2015.
    - Of this number, 118 (or 44.9%) live outside the local authority area
    - 11 live in residential children's homes, of whom five (45.5%) live outside the authority area
    - Two live in a residential special school,[3] both of whom live outside the authority area
    - 205 live with foster families, of whom 43.4% live outside the authority area
    - 10 live with parents, of whom five (50%) live outside the authority area
    - Four children are unaccompanied asylum-seeking children.
- In the last 12 months:
    - There have been 24 adoptions
    - 19 children became subject to special guardianship orders
    - 114 children ceased to be looked after, of whom 10.5% subsequently returned to be looked after
    - 26 children and young people ceased to be looked after and moved on to independent living
    - Two children and young people ceased to be looked after and are now living in houses in multiple occupation.

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

Recommendations

1. Improve the quality of management oversight and decision making at all levels to ensure that children experience good-quality assessment and care planning to meet their needs in a timely way.

2. Ensure that the results of quality assurance work and independent reviews are analysed, reported and monitored in a way that makes explicit to staff and managers the impact of practice on children and the improvement that is required to deliver good-quality services.

3. Ensure that visits to children are undertaken in line with their plans, and take appropriate action when this is not the case.

4. Ensure that thresholds are applied consistently, so that decisions relating to contacts and referrals to children's social care are appropriate, and that these are well informed by appropriate checks with other agencies.

5. Ensure that children become looked after without unnecessary delay, when this is what they need, and improve the monitoring of this process.

6. Ensure that children receive ongoing help and support as children in need until this is no longer required.

7. Ensure that child protection investigations are consistently completed within timescales that are in line with statutory guidance, so that children receive the services that they need as soon as they can.

8. Strengthen step-down arrangements between statutory and early help services to ensure that decisions to step down are appropriate and that children receive an effective continuum of support.

9. Strengthen the quality and oversight of assessments and plans for children in need of help and protection, including children affected by domestic violence.

10. Ensure that arrangements for children placed at home with parents under a care order are suitable, and that appropriate action is being taken to secure permanence for these children.

11. Ensure that information presented to elected members provides enough detail of performance, quality assurance or other independent reviews to give them a full picture of the quality of the frontline practice that children experience.

12. Develop and improve the consultation with, and participation of, children and young people, in respect of informing service development and monitoring service quality.

Summary for children and young people

- The help that most children get when problems begin to appear makes things better for them.
- When someone says that they are worried about a child, managers often make the right decision about what should happen next. A few children are let down and don't get the help that they need as quickly as they need.
- Children who need some help, but don't need to come into care or have a child protection plan, don't always get help for as long they need it to make sure that things have really changed for the better.
- Children only come into care when they need to. For some children, this doesn't happen as quickly as it should.
- The top managers do not know everything that they should about how well children are being helped by their social workers. During the inspection, managers made sure that they found out what they needed to know. The council is not as good as it could be at listening to what children think about the things that the council does and using this to make things better.
- Social workers know what is happening for children, but do not always visit them as often as they should to get to know them well in person. This means that they do not always help children to understand the plans for them as well as they should do.
- There is a good choice of places for children and young people in care, so social workers can make sure that children have a carer who is the right one for them to live with.
- When children need to live with new 'forever' families, this happens quickly for most of them. Some children do wait too long to find out that they can stay with their foster carers until they leave care.
- Young people get the help that they need to leave care and to move on to living in their own places. They feel safe where they live and get on well with their workers.

The experiences and progress of children who need help and protection	Requires improvement

Summary

Children and their families receive well-coordinated, holistic support through the local authority's early help provision. These preventive services are easily accessible and families benefit from a wide range of interventions, depending on their assessed needs.

Although most decisions on initial contacts with children's social care are made in line with appropriate thresholds, in some cases decision making is overly optimistic and too reliant on perceived protective factors, without all appropriate checks being completed. This means that decisions on some contacts have led to children not receiving the support that they need as soon as they could. In one case seen by inspectors, the local authority had to take emergency action to make children safe.

Strategy discussions are timely, but do not always involve all relevant partners at the outset. Although fuller information is gathered during the investigation, this limits the effectiveness of initial planning. As a result, child protection investigations take too long, and this delays the development of full multi-agency plans for children. Due to inaccuracies in the methodology of measuring the length of investigations, prior to the inspection the local authority had not identified this failing.

Child in need and child protection plans are not consistently strong enough to support good-quality interventions that improve children's circumstances in a timely way. Some plans lack clarity about the desired outcomes for children and the timescales for these to be achieved. This limits the ability of parents and professionals to understand what needs to change, and when by.

In most cases, child protection plans end when risk has been reduced. In a small number of cases seen by inspectors, decisions to end plans were premature and repeat plans became necessary. Similarly, 'child in need' work does not always continue for long enough to produce sustainable change for children, with some cases being stepped down too soon and then re-referred.

Social workers receive regular formal and informal supervision from line managers. Senior managers are visible, and social workers feel able to approach them for additional support and case direction. However, management oversight and challenge are not sufficiently effective to drive plans forward, leading to delays.

Parents speak highly of relationships with social workers and the wide variety of services that they receive.

Inspection findings

13. The local authority recently remodelled its early help services. This brought together a wide range of provision from a number of specialisms into a single service. Services are now easily accessible for children and families through a single 'front door'. Service users and practitioners can also access early help information through a universal website. The wide range of interventions accessible under early help provision are also used extensively for children in need and children subject to child protection plans. Effective work by these services was seen throughout the inspection.

14. Southend has developed and implemented an early help assessment tool to replace the common assessment framework. A well-embedded team around the child and family approach is used to improve outcomes for children and young people, and to provide them and their families with early support. Managers review all requests for support. When an emerging need is identified, it may be addressed through one of three pathways. High- or complex-need cases are referred to the 'Streets Ahead' service, which provides intensive support. Cases with lower levels of need are responded to through multi-agency children and family panels, which allocate the most appropriate lead professional and carefully consider the most appropriate interventions. At the lowest level, families are supported by a team around the child and family.

15. Early help assessments are routinely quality assured and measured against a set of minimum standards. The majority of assessments provide a clear overview of children's circumstances and the concerns for them, and include the views of children and parents. Some assessments do not provide sufficient analysis of the impact of the circumstances on the child.

16. A large majority of children within the early help service are receiving the right level of intervention in line with the local authority's thresholds for early help. However, step-down arrangements from social care to early help are not sufficiently well embedded in practice to ensure that the transition from statutory intervention to early help always works well for families. Although examples of good transitions were seen, including early help practitioners attending child in need meetings, the cases of a small number of children are closed by children's social care without an effective handover, meaning that arrangements are uncoordinated and lack appropriate information sharing. As a result, children and families do not always experience a continuity of service or have their needs met in good time. This also leads to some children having to be re-referred to children's social care. (Recommendation)

17. There is a single point of entry to children's services though the contact and referral service. One of three practice managers decides whether additional action is required on contacts, and those requiring further action become a referral. Referrals are allocated promptly to suitably qualified social workers. Information is shared effectively between day-time services and the contracted out-of-hours service through case note records on children's electronic files.

18. The application of thresholds by children's social care is inconsistent. Inspectors saw a number of cases within the duty system which had been closed by managers, despite the presence of risk indicators. In some cases, particularly when non-professionals were reporting concerns, checks had not been made with other agencies such as schools, on the assumption that they would have made contact if they were concerned for children. This lack of professional curiosity means that managers make decisions without all the relevant information. Following concerns raised by inspectors about contacts that had been closed, the local authority arranged home visits to a number of children. In all but one case, children were found to be safe. In the case where children were not, the local authority took swift, appropriate action to secure their safety. (Recommendation)

19. Following feedback from the inspection team, the local authority commissioned a review of all contacts received during a single week in the previous month. This identified that 84% of decisions were appropriate. Of the 16% that were not, contact decisions involving domestic abuse, parental mental health or substance misuse, in particular, were overly optimistic in terms of the weight given to perceived protective factors. The local authority took action immediately to address this shortfall in practice, but this change was too recent to have shown impact during the inspection.

20. The local authority has challenged the police service about its request that social workers call the public 101 telephone number to log possible child protection concerns and secure police engagement. Social workers reported long waits of up to an hour on the phone before receiving a response. This has the potential to delay action for children and does not represent good partnership working. The local authority reported that this practice was soon to change. Specialist police officers are not always available to carry out joint visits or investigations when a child may be at risk of significant harm. This results in social workers undertaking these alone, without the support of police powers of protection.

21. Southend's practice with children in need is to allocate them to their short-term first contact teams, with a view to closing their cases quickly. Only in specific circumstances, such as when children are privately fostered or when they have had a child protection plan which has been brought to an end, do the longer-term care management teams work with children in need.

22. The quality of interventions for children in need is too variable to ensure that children's needs are consistently met and change achieved. There was evidence of some effective work being undertaken, for example in preparing a young woman for motherhood while reducing risks presented by family members. However, the short-term support received by children assessed as requiring help as children in need is not always sufficient to produce sustained change for them. For some children, the decision to step down from social care to early help is premature, with insufficient assessment and planning to support this decision. This can result in re-referrals to children's services. Examples were

seen of cases that had been re-referred soon after the end of child in need plans, as concerns had re-emerged. Inspectors raised concerns about two cases that had recently been closed as children in need, resulting in them being reopened as children in need by children's social care. However, these children had not been left at immediate risk. (Recommendation)

23. Southend's overall approach to the initial stages of child protection investigations is not in line with statutory guidance. The local authority holds strategy discussions promptly when social workers judge that a child is at possible risk of harm. However, these involve only the police, not the wider professional network. This narrow participation means that decisions do not have the benefit of full consideration of information from other professionals. The majority of the strategy discussion records reviewed lacked detail about next steps.

24. During investigations, a series of review strategy meetings are held and, in most cases, these do have wider professional participation. However, there can be delays between the initial strategy discussion and the first strategy meeting. As well as this, strategy meetings do not always make decisions which progress cases in a timely way, even when sufficient information is available to do so. The overall effect is a system which can cause significant delay in completing child protection investigations, with the worst cases seen taking between three and seven weeks to reach a conclusion. Although children are seen during this time and none were seen who had been left at risk, this creates delay in formulating coherent multi-agency plans to meet their needs. (Recommendation)

25. This failing in practice had not been identified by managers prior to the inspection, as performance had been measured from the first strategy meeting rather than the initial strategy discussion. This concealed the extent of the delays. Analysis during the inspection showed that only 28% of children benefited from compliance with the statutory expectation that there should be no more than 15 days between the start of an investigation and an initial child protection conference.

26. Assessments are not consistently providing a sufficiently clear, comprehensive picture of children's needs and circumstances to allow effective plans to be made for them. They do not always consider all key risk factors, or provide sufficient analysis to make sense of the life and experiences of the child. In the poorest assessments, social workers have not made full use of history to inform decision making. For example, in one case, medical evidence from a previous investigation was not included in the assessment. Chronologies are not routinely used, and the engagement of fathers and the wider family was not evident. Assessments gave little consideration to issues of culture or diversity. Some assessments were much better, giving a clear picture of the child's life and the impact that any risks had on them. (Recommendation)

27. Plans are not robust enough to support interventions that improve children's situations effectively. They lack clarity about what needs to change for children and by when this should happen. In some cases, they are too adult focused. Timescales for actions that are set during child protection conferences default to the following child protection review date, rather than being clear about what needs to happen first. This lack of prioritisation limits parents' and professionals' ability to measure the impact of the plan. Parents reported that they did not fully understand what was required of them or what progress had been made. (Recommendation)

28. Visits to children are not always in line with their plan. The local authority's data for March 2016 shows that visits were in line with plans for only 51.3% of children. As a result, children are not seen regularly enough to build relationships with social workers, or to ensure that the plan is delivering direct work that is reducing risk and improving their lives. (Recommendation)

29. When children are seen, they are seen alone. Social workers use specially developed toolkits to help them to work effectively with children. However, there was little evidence of this work on children's files. The voices of children and young people are not always evident in social work practice, but this is better for older children and young people. Some records seen by inspectors gave a good picture of young children and their interaction with their parents and environment, but assessments and reports did not reflect this well, often simply stating that children were too young to give their views.

30. Child protection conferences are well chaired, and facilitate information sharing through good attendance and engagement from partner agencies. Conference reports from partners use the strengthening families model. This contributes to making the conferences an effective forum for identifying risks, strengths and grey areas.

31. Parents value relationships with social workers, although they are not well prepared for child protection conferences. In too many cases, they do not receive reports prior to the meeting. This limits their ability to participate effectively in the meeting.

32. Core groups share information, but do not effectively drive forward the plan for the child. Monitoring completed by child protection chairs in January 2016 identified that only half of the plans had been fully implemented between reviews.

33. A high proportion of children are subject to a child protection plan for a second or subsequent time, with 22.6% of those becoming subject to a plan in the year prior to the inspection having had a child protection plan previously. This is a higher proportion than the most recently available figure for similar local authorities (18% in 2014-15) and the average across England (17% in 2014–15), and a rise from the local authority's own figure of 16% for 2014–15. Further analysis of the figures shows that 9% of those with current plans were

subject to plans within the last two years and 5% within the past year. This suggests that, in most cases, child protection plans for these children had been ended appropriately.

34. However, a small number of children were seen who had had their plan removed when risks had not been sufficiently reduced, and sustained change was not evident although some progress had been made. These children had had to have new child protection plans put in place soon after the previous plans had ended. Child protection plans are appropriately removed when children became looked after.

35. The response to children at risk of domestic abuse is not sufficiently robust. Deficits in multi-agency risk assessment conference (MARAC) arrangements were identified by the LSCB and the local authority in 2014. Work was undertaken on this during 2014 and 2015 and a new multi-agency risk assessment team (MARAT) is due to come into operation in June 2016, but this development has taken too long. At the time of the inspection, police notifications of domestic abuse incidents involving children were looked at daily by a local authority practice manager who gathered additional information from the police on high-risk cases. This was then passed to the joint domestic abuse triage team for a decision about whether the case should be heard at MARAC. However, there is no system for monitoring the progress on the responses to children that are presented to the meeting. At the point that children's services close the cases, too often there is reliance on a belief that risk has been reduced if the victim is willing to engage in support. This is without any analysis of how this has reduced risk, or any verification that it has. There are limited interventions with unconvicted perpetrators to address their behaviour, with no dedicated service for this available in Southend. (Recommendation)

36. There is strong commitment by the local authority and partners to tackling child sexual exploitation through the missing and child sexual exploitation panel, which builds on the work of the LSCB sub-group to counter child sexual exploitation and risk of children going missing. There is evidence of it profiling and sharing intelligence and information, including about gang activity, child sexual exploitation and data on children missing. However, the panel is still in its infancy, and it is too soon to measure its effectiveness.

37. Children known to be at risk of child sexual exploitation have comprehensive and detailed risk assessments, although it is not always clear how these link to plans to keep children safe. However, risks associated with child sexual exploitation are not always identified at the point of referral or appropriately escalated when referrals have identified this as an area of concern. Although most staff have had basic child sexual exploitation awareness training, only 57% have been trained in the use of the local authority's child sexual exploitation assessment tool. This reduces the likelihood that these risks will be effectively assessed and reduced.

38. The local authority has a good knowledge of children who go missing through systematic review of referrals from the police. A dedicated coordinator reviews all notifications about children missing and child sexual exploitation effectively, and collates additional information and intelligence from a number of different databases to assess initial risks. Information from return home interviews is given to social workers when children are already in receipt of services, or used to request services through early help or children's services. There is too much variability in the timeliness and quality of return home interviews. Not all give an adequate picture of the reasons for children going missing or an effective assessment of the risks. Some interviews are undertaken in the presence of significant adults, potentially limiting young people's ability to speak candidly about their reasons for going missing.

39. The local authority is developing its understanding and response to girls at risk of female genital mutilation. In partnership with a national charity, the local authority now has a dedicated worker to raise awareness, strengthen referral pathways, and support appropriate and effective interventions. Over the past 12 months, one child has been identified as being at risk of female genital mutilation, and has been safeguarded through child protection procedures.

40. The local authority takes effective action to prevent children going missing from education (CME) and robustly monitors cases where this occurs. Investigative action when children are reported to be missing education is swift and thorough. The local authority has established a CME case management group which discusses each case in detail. The CME action plan is detailed and very effective. Actions are recorded clearly and focus on a wide range of issues that will help the authority to identify children who may be at risk of missing education.

41. The local authority is good at keeping in touch with children who are electively home educated. Currently, 106 children are home educated. The authority has established effective partnerships with most of these children's home educators.

42. Year on year, the local authority has successfully reduced the proportion of children who are not in education, employment or training (NEET). In 2015–16, 3.6% of young people were known to be NEET, with the status of 6.6% unknown. These figures are in line with the average for the region. Leaders have implemented a range of initiatives which have helped to address this issue. Managers share information with other services to identify young people at risk of becoming NEET, and work well with these groups and external partners to provide a range of positive incentives for young people. These include working with the local football club to help young people to gain sports qualifications.

43. The local authority is aware that, at the time of inspection, 48 children across Southend were not receiving their full-time entitlement to education. While the

reasons for this are well understood and robust plans are in place to address this in individual children's cases, this persists as an issue of concern.

44. The local authority and its partners have established effective multi-agency arrangements to protect children at risk of radicalisation. The Channel panel identifies individuals who are at risk, assesses the nature and extent of the risk, and develops effective support plans to divert young people away from extremist behaviour. These include providing services to meet the wider needs of the child and their family.

45. Arrangements to support and assess 16- and 17-year-olds who are homeless are not sufficiently robust. Young people presenting as homeless are provided with emergency hostel accommodation and key-worker support to ensure that their needs are met in the short term, while social workers engage with families to try to facilitate a return to home or to the wider family. However, there was no evidence of young people being informed of their right to become looked after. When assessments were completed, a large majority were appropriate in identifying risks and protective factors, leading to effective planning and positive outcomes.

46. Vulnerable teenagers have access to a wide range of supported accommodation options. Bed and breakfast accommodation is not used. Arrangements to identify long-term accommodation are well coordinated, with a multi-agency panel reviewing each young person's needs and identifying their particular care and support requirements.

47. Children who are privately fostered are supported well. The assessment and oversight of privately arranged foster placements are well led by a knowledgeable and committed practitioner and group manager. Formal processes, including a dedicated panel, provide a good level of scrutiny. There is clear evidence that the local authority uses its prohibition powers where appropriate. Children's records show that children and their carers benefit from a level of visiting and support that exceeds minimum requirements. This helps children to stay safe and to progress.

48. The local authority's designated officer is an experienced senior manager. She also undertakes other roles which complement her designated officer role, including linking with schools. Effective management systems are in place to track enquiries and referrals, information gathering, decision making and actions. Decisions and actions are appropriate.

The experiences and progress of children looked after and achieving permanence	Requires improvement

Summary

Outcomes for children improve once they come into care, and they benefit from the support of good foster placements. However, many children become looked after in an emergency and there are delays in progressing plans to initiate legal proceedings. For a very few children seen, this had resulted in them remaining in harmful situations for longer than they should, although the local authority was actively trying to manage the risk to them during this time.

Too many children's assessments and plans require improvement. This means that the local authority does not always have a sufficiently clear picture of children's needs and that plans do not drive change for children as effectively as they should. Concerns about children who go missing from care are reported and tracked appropriately. Reports of return home interviews completed after 'missing' episodes do not always contain sufficient analysis to ensure that risk management is robust. The majority of children benefit from placements which meet their needs and help to improve their outcomes. They are placed with carers who know them well and who are proactive advocates for them.

The local authority has increased the capacity of the independent reviewing service over the past year. This has allowed independent reviewing officers (IROs) to develop closer relationships with children. However, when IROs raise issues of concern on cases, they are not yet always effective in producing positive resolutions for children. Most social workers know the children and young people allocated to them well. However, their good understanding of children's needs is not reflected in children's electronic records. This means that the child's journey is not clearly set out when they transfer from one social worker to another.

Educational support for children looked after requires improvement. Children do not achieve as well as they should. The authority has only recently used data robustly enough to understand their educational needs and to drive improvement.

Children whose care plan is for long-term fostering wait too long to be formally matched with their carers, although they may have been settled in the same placement for a considerable length of time. This creates uncertainty for them.

Southend is successful in pursuing permanence for children through adoption. Parallel planning at an early stage ensures that children are appropriately placed within timescales that meet their needs. Adoptive families continue to receive good support from Southend post-adoption services for as long as this is required.

Care leavers are well supported in their transitions to adulthood. Young people are provided with an appropriate range of support and accommodation, and feel safe where they live. Care leavers are very positive about the service that they receive.

Inspection findings

49. At the time of the inspection, there were 261 children looked after. Children become looked after when there is clear evidence that this is required to reduce risk and improve outcomes. However, this often happens in an emergency due to escalating risk, which limits the opportunity for planning and preparing children for these significant changes. In two cases seen by inspectors when children had recently come into care, the three children involved had remained in harmful situations for longer than they should have done, due to delay in progressing plans. (Recommendation)

50. Decisions about children becoming looked after are made by a senior manager. However, there is currently no strategic overview of the reasons for children becoming looked after to inform practice. The local authority had already identified this as an area for development. It was putting in place a panel to consider all newly looked after children and to ensure that there is ongoing management oversight of care planning.

51. When children return home from care, there is a lack of purposeful planning and support to ensure that the plan is sustainable in the long term. Children have a child in need plan to guide the work with them, but social workers do not always visit in line with the plan to progress this effectively. However, only a very small minority of children currently looked after have previously been in care.

52. Tracking mechanisms are in place to monitor the progress of children through legal planning meetings and the pre-proceedings process of the public law outline. However, these are not sufficiently effective. The local authority practice is to hold a departmental planning meeting to decide whether a legal planning meeting is needed. The time between these meetings is not tracked closely enough, leading to delay in progressing plans for children when legal planning meetings do not happen within suitable timescales. The IRO challenge log highlights the cases of six children over the past 12 months where concerns have been raised about drift in issuing proceedings. During the pre-proceedings process, the local authority arranges the appropriate assessments quickly to ensure that delays are minimised once cases are in court.

53. The local authority has worked effectively with the courts to reduce timescales for care proceedings. The majority of cases are concluded within the expected 26-week timescale. Statements and care plans presented to court are of good quality, though papers are not consistently submitted within timescales. The local authority's positive working relationship with the courts, alongside the courts' flexibility in altering timescales to account for delays, means that late filing of papers does not affect the overall timeframe for proceedings. As a result, children benefit from plans being made for their futures without undue delay.

54. In some cases, social workers lack confidence and experience in giving oral evidence in court, which means this is not always presented as effectively as it could be. The local authority has held discussions with the children and family court advisory and support service (Cafcass) with a view to offering training for social workers. This is to equip them with the skills that they need to undertake good assessments and plans, and to develop their skill in presenting in court.

55. The local authority has made a number of applications for court orders following a recent review of cases of children looked after under voluntary arrangements. This demonstrates positive action to secure permanence for, and to safeguard the welfare of, children unable to return home.

56. In most cases, parallel planning for children in care proceedings is undertaken appropriately, including the assessments of connected persons. While some assessments of connected persons are very thorough, with full exploration of the circumstances, others are of poor quality with gaps in information. Delays in receiving formal checks on carers mean that some assessments are not completed within statutory timeframes.

57. There is delay in achieving permanence for children with a plan for long-term fostering. This is in contrast to those with care plans for adoption or special guardianship, who benefit from an effective system of tracking cases and progressing care plans. At the time of the inspection, 56 children, just under a fifth of children in care, were waiting for a long-term fostering match to be formalised, despite having been in placement for 12 months or more. This creates uncertainty for children. A linking panel has very recently been introduced to formalise matches, but has yet to show impact.

58. A large majority of assessments require improvement so that they detail children's needs effectively and thus ensure that suitable plans are made for them. Assessments are not always updated to take full account of children's current circumstances. They do not make good use of historical information, and lack detail and analysis. Examples were seen of better-quality, child-focused assessments which incorporated all aspects of children's lives and relationships, and the impact of risk. Risk factors were balanced and clear, and historical factors were considered in relation to current decision making. (Recommendation)

59. The quality of most care plans for children who are not in the court process is poor, and plans are not effective tools to guide work with children and young people or to guard against drift and delay. They are not always based on up-to-date information and do not always reflect the full range of children's needs. Plans lack clarity about timescales and the outcomes to be achieved. The independent reviewing service challenge log notes a number of cases in the past year when IROs had not been informed of changes to care plans. Despite the poor quality of plans, most children have a positive day-to-day experience of care due to the good quality of placements. (Recommendation)

60. At the time of the inspection, only two thirds of children had been visited in line with statutory requirements. Records on children's electronic case files indicate that social workers are not spending enough time doing direct work with children to get to know them well and support them as effectively as they can. (Recommendation)

61. Children have access to a well-publicised advocacy service. This is routinely discussed in their review meetings. Particularly positive examples of this service being used well were seen in respect of children and young people with limited communication skills. In these cases, children and young people had been supported by an advocate working with them over a period of time to gain their views and to ensure that these are represented clearly at their review meetings.

62. The independent visitor scheme is underdeveloped, with only one young person currently accessing this service. The IRO challenge log notes that, between November 2015 and March 2016, IROs raised concerns about 12 children and young people for whom an independent visitor would be appropriate, but for whom referrals had not been completed by their social workers.

63. Numbers of children placed at home with parents on a care order are below the national average, but plans for them are not always sufficiently well considered. In particular, some of these arrangements are seen as being long term, with no consideration being given to the discharge of care orders or making alternative plans if the arrangement is not felt to be sufficiently robust for this to be achieved. Overall, there is a lack of clarity both around planning for children placed with parents and of robust oversight of the suitability of these plans. (Recommendation)

64. Children looked after receive the healthcare that they need, in the large majority of cases. This includes those placed outside the local authority. Local authority data for the first quarter of 2016 shows that 92% of children and young people who have been in care for 12 months or more have a current health assessment. However, conducting initial health assessments when children come into care requires improvement. Increased monitoring by the nurse for children looked after and the senior manager with responsibility for children looked after has improved timeliness, but the data shows that the proportion completed on time, as at January 2016, was still only 61%. This remains an area of challenge for the local authority. (Recommendation)

65. Children and young people who need specialist help with their emotional health needs have been waiting too long. A new contract to improve access will be in place from June 2016, but this does not include a fast track referral system for children looked after. The nurse for children looked after has raised this as a concern. Strengths and difficulties questionnaires are completed as part of the review health assessment.

66. The proportion of children looked after who attend a school rated by Ofsted as good or better is 69%, with 11% attending a school that is graded inadequate.

This is in line with national averages. Virtual school staff now work more closely with schools, particularly those in need of improvement. This has increased the level of support that they provide for children. However, the virtual school has only recently started to monitor how outcomes of children looked after vary across different schools.

67. Children looked after do not achieve as well as they should. Overall, the gaps between children looked after and those not looked after widened in 2014/15. Key stage 4 results for children looked after dropped significantly in 2014/15, with 6% achieving A* to C grades in five GCSEs, including English and mathematics. At key stage 2, while children achieve broadly in line with the national average in reading, they achieve less well in writing. Local authority predictions for 2015/16, based on analysis of individual progress, indicate that results will be higher this year.

68. Although now improving, the monitoring of the quality of education for children looked after has not been sufficiently robust. The local authority analyses information from personal education plans, but does not routinely monitor the quality of these plans to identify strengths, weaknesses and trends. Improvement action plans are not effective improvement tools. The local authority has put in place more robust measures for monitoring the quality of education for children looked after, for instance by carrying out observation visits to schools. However, it is too early to see the impact of this work.

69. The attendance of children looked after at school is poor. In 2013/14, 9.3% were persistent absentees. The local authority's data for 2014/15 shows that attendance improved for those at primary stage but remained poor at secondary stage, at 91%. Attendance figures fall as children progress through secondary education, from 96% in Year 7 to 86% in Year 11. This is lower than the national average for children looked after. Virtual school staff have put in place actions to improve attendance, and the figure at the time of inspection was better than at the same time last year.

70. Most personal education plans require improvement. Although they contain basic information, discussions about meeting aspirations are poorly recorded. There are also poor records of academic progress and a lack of detail in recording prior attainment. The local authority had identified these issues through audit, and has put in place actions to improve the quality of plans.

71. The use of pupil premium funding is not monitored closely enough. The funding is distributed each term in response to children's personal education plans. However, too often these have been insufficiently detailed and have not evaluated the impact that the funding has had on the child's progress. The local authority is aware of this weakness and is taking appropriate action. As a result, in this academic year education partners report receiving greater challenge from the local authority about how the pupil premium is used.

72. Following a period with significant vacancies, the independent reviewing service is now fully staffed. The authority has improved working relationships by co-locating IROs with operational managers. IROs are each responsible for about 60 children. These manageable caseloads allow them to meet with children prior to their reviews to build relationships and to ensure that children's views can be shared in these meetings. However, they are not consistently effective at moving plans on for children. Although they make use of the escalation process to highlight drift on cases, the impact of this on the overall quality of the work has yet to be felt.

73. The quality of placements for children is a strength, with foster carers providing stable and nurturing care for children. They advocate effectively on behalf of children and young people to address weaknesses in practice, being proactive in challenging social workers. Foster carers express concern at the number of changes of social worker that some children and young people have had in a short space of time. These children naturally find it difficult to engage with a new social worker, lacking confidence that they will remain them for any length of time.

74. The local authority has ensured that a good choice of placements is available. Although a high proportion of children live outside the local authority boundary (52%), most live within 20 miles of their home. This allows them to maintain contact with those important to them. In most cases, children are able to live with their brothers and sisters. Placement stability for children looked after is good, with 9% of those looked after at the time of the inspection having had three or more placements in the previous 12 months. This is slightly below the most recently available figures for similar local authorities and England as a whole.

75. Children looked after are able to access a range of leisure activities, and examples were seen of the pupil premium being appropriately used to facilitate this. Foster carers exercise delegated authority for most children, although some carers said that they remained unclear about what they can and cannot do. In some cases, this was linked to not receiving detailed written information about children prior to or at the time of their placement. Although the quality of the information given to carers is good, carers feel that caring for a child without having the information from the start creates difficulties, both for them and for the child.

76. Children and young people who go missing from care are reported promptly. However, the quality and timeliness of return interviews are not consistently good, with examples seen of these being conducted by adults who are not sufficiently independent. The quality of risk management plans to address and minimise 'missing' episodes also requires improvement. Examples were seen of risks being set out clearly, but without a coherent and effective plan in place to ensure the young person's engagement.

77. The Children in Care Council requires more support from the local authority to improve its influence. Historically, an active group of older young people has participated in dialogue with the local authority to influence the delivery of services to children looked after, supported by a participation officer. The current group of younger children are enthusiastic, but mainly operate in a consultative role rather than being supported to be active participants in the critique and development of services.

78. The consideration of diversity for children in care is not consistently well done. Social workers do not always demonstrate an understanding of the full breadth of diversity issues, with a narrow focus on ethnicity and language. For example, for one young person there was no consideration of the nature and impact of gang culture, when this would have contributed to a rounded understanding of the young person's needs.

The graded judgement for adoption performance is that it is good

79. Permanence through adoption is actively pursued, and children for whom adoption is planned move in with their new families at the earliest opportunity. The adoption service uses a weekly tracker to identify children coming into care, which triggers early adoption notification meetings. Tracking meetings then monitor children's progress, and parallel plans are put in place at an early stage. The local authority's attention to parallel planning, assessing family members and planning for adoption, even where reunification is the primary plan, have enabled it to improve timescales for achieving permanency. Partnership with courts is also instrumental in achieving this.

80. The timeliness of adoption in Southend is good, and shows year-on-year improvement. The local authority's provisional figure for 2013 to 2016, for the three-year average time between a child entering care and moving in with their adoptive family, is 386 days. This is a reduction from 505 days on the last-published adoptions scorecard, and is better than the national target for 2013 to 2016, of 426 days. The average time from a court making an order to the local authority approving a match between child and adopter has also decreased, from 144 days in 2012 to 2015, to 119 days for 2015–16, just inside the national target. Most children for whom adoption is the plan are placed with their adoptive family within 16 months of entering care. This is of significant benefit to children and their new families.

81. A higher proportion of children in Southend leave care through adoption than the England average, supported by effective planning. At the time of the inspection, six children were waiting for a placement order to be made, and nine with placement orders were waiting for a suitable placement. Thirty-nine children have been matched to prospective adopters since October 2014. Of these, three are in the process of introduction to their new carers, 14 are living

with their adoptive families, awaiting an adoption order, and the remaining 22 children have had their adoption orders granted.

82. In the last year, three children, or 13% of those with plans for adoption, had their plan changed. As a proportion, this is just below the England average of 14%. These changes of plan were appropriate, and followed extensive consideration during the court process, including consultation with children. All three children are now placed in suitable alternative permanent placements.

83. One third of adoption placements are made to out-of-area carers, demonstrating a focus on finding the best match for children rather than using only carers approved by Southend. The local authority has successfully placed higher than national average numbers of minority ethnic children and children aged over five for adoption. It continues to find suitable adoptive families for children with disabilities and complex health needs. Sustained and effective efforts are made to place brothers and sisters together. Decisions to separate brothers and sisters are based on assessments, but these are not always of good quality. The local authority has plans in place to address this.

84. Workers speak confidently about the use of 'fostering for adoption' placements, although currently only three children are in this type of placement. In the light of the high proportion of children aged one or under who are placed for adoption, many more children could benefit from early placements with carers who are likely to go on to adopt them. This needs more focused attention, along with concurrent planning. (Recommendation)

85. Adopters and prospective adopters are positive about the local authority. Prospective adopters come from a range of backgrounds and lifestyles, including older carers, single carers and same-sex carers. At the time of the inspection, three sets of adopters were at stage one of the process, six were at stage two and four were on hold. At the time of the inspection, 22 approved adopters had not yet been matched.

86. As part of the regional adoption consortium, adoption social workers actively support adopters to use the adoption register and other linking services. The local authority uses the income from the fees paid by other agencies for the use of its adopters to provide adoption support. Approved adopters confirmed that they continue to receive support from the local authority, even when children from other authorities were placed with them.

87. Prospective adopters receive excellent support through the assessment stages from a stable team of social workers, all with relevant post-qualifying qualifications. Allocated workers keep prospective adopters informed at every stage, noting reasons for any delay, with timescales. Prospective adopters are helped to work at their own pace through the assessment stages. Training is of a high standard and provides a realistic appreciation of what it means to adopt a child and remain focused on the child's needs. Carers described the assessment process as thought provoking and thorough.

88. Adoption assessment reports are of a good standard. More recent assessments are more comprehensive and detailed, give a fuller appraisal of prospective adopters' journeys to adoption, list their strengths and areas of challenge, and make clear recommendations. In one case, delays were due to appropriate investigation of medical references and second opinions being obtained.

89. Children's assessment reports are sufficiently detailed and provide an informative record of the child's early life. They provide a clear picture of the child, covering their journey sensitively and including proposed contact arrangements with family members.

90. The effective adoption panel is chaired by an experienced and suitably qualified chair, who also chairs the local authority's fostering panel. Members of the panel are experienced practitioners, and an independent adoption advisor ably supports the panel. Prospective adopters and social workers are encouraged to attend to present their views and to answer questions. Panel minutes reflect a full and frank discussion, with gaps or queries explored, resolved or noted for follow up. Detailed decision sheets clearly note the reasons for decisions and these, along with a record of issues of non-attendance and other issues of concern, are forwarded to the agency decision maker in a timely way.

91. The adoption service produces a statement of purpose and an annual report, both of which are detailed and readable, and serve as a clear introduction to the service. However, the adoption panel does not produce an annual report on its work. This is a missed opportunity to gather together key themes, and to help to identify and drive improvements in adoption performance.

92. Linking and matching are carried out well. Children's needs are clearly identified alongside information on how carers would meet these. Gaps are considered and support plans drawn up before the formal matching stage. Introduction plans based on a standard template have the child at their heart. Adopters spoke of their appreciation of the support offered during this period, which allowed them to remain focused on the needs of the child through this challenging transition.

93. Following the granting of adoption orders, children's cases are closed by allocated social workers without always ensuring that outstanding tasks are fully completed. In particular, life-story work may not have been undertaken with the child and there may be more to do to finalise contact arrangements. Although it is expected that adoption social workers will then cover these tasks, closing summaries are of poor quality and do not clearly state outstanding actions. This means that it is not always clear that actions will be followed through.

94. Life-story work is child focused, containing relevant and sensitive information about children's birth families, and other key people and places in their life journeys. Information is age appropriate. Children are also given the opportunity to revisit life-story work in their teens. However, adopters reported

that life-story work often delayed in its completion. Managers recognise that there is delay, and actions are now in place to address the backlog.

95. Following approval, carers are encouraged to remain in contact with the adoption service and with each other. An extensive range of support is available for children and adopters. They are routinely sent helpful information, invitations, newsletters and advice, including information on specialist support and universal services. Creative use is made of the adoption support fund to pay for a highly regarded residential weekend for older children and their adoptive families, in addition to individual packages of support.

96. Support for families is good. In the last two years, the service has received 28 requests for post-adoption support. Twenty-three families are currently receiving post-adoption support. Of these, 13 adopted their children more than three years ago. Many more families are supported through attendance at groups, training and other forums. Carers spoken to were highly appreciative of and valued the ongoing support, and felt able to request support when required.

97. The local authority has been successful in engaging with and supporting birth families to provide information for life-story work and memory boxes, and introductions to adopters and contact sessions. Ongoing work is offered to the birth parents of children, beyond the adoption of their children.

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

98. Southend is currently supporting 92 care leavers. Young people transfer to the 16+ case management team after their 16th birthdays and stay with this team after they leave care. Care leavers are overwhelmingly positive about their experiences with the team. They appreciate the support that social workers and personal advisors provide to help them to develop their skills. They feel that workers know them well and support them to develop independent living and other life skills.

99. In most cases, pathway plans are detailed and up to date, and management oversight of plans is robust. Young people's progress and needs are clearly identified, including in relation to health and education. Skilled help and effective partnership with adult services ensure that young people with learning difficulties and disabilities are supported well in their transition to adulthood. Plans are regularly reviewed with young people, and their views and experiences are clearly taken into account. However, the format for plans has not been devised in consultation with young people with a view to being useful documents for them to use effectively themselves. As a result, they are too

long and complex, and duplicate information. Although risks are identified clearly, contingencies are not.

100. Personal advisors maintain regular contact with care leavers and know them well. The service is in contact with all but one care leaver. Workers are committed to and passionate about achieving the best for young people, and they build positive relationships with them. Records of each contact are detailed and updated regularly.

101. Care leavers receive effective advice and guidance about health issues. Young people are clear that these issues are dealt with well. Specialist advice is made available to young people in a range of ways. These include visits to 16- and 17-year-olds where they live, and planning for health professionals to be available at times when young people will be visiting the team's base, for example for drop-in events such as barbeques.

102. Young people over the age of 16 receive a health passport based on their health assessment. This is regularly updated. Young people can have the information either as a print-out or as an application on their mobile phone. This means that they have a record of their health information, in the format of their choosing, to assist them with their transition into adulthood. In the past year, managers have focused on increasing the proportion of children who engage with this process. At present, 93% of care leavers have a health assessment.

103. Access to mental health services for care leavers has recently changed. Previously, care leavers had access to mental health services through an additional post that was able to provide a response within a few days. It is too early to say if the new contract will be effective in meeting the needs of care leavers.

104. Staff working with young people find creative ways to engage with them successfully. General events include healthy cooking activities, CV-building sessions and drop-in events. These are well attended by young people. Personal advisors, senior staff and a range of other professionals make good use of the informal atmosphere provided by the team base to engage with young people. Professionals involved include Connexions staff, the nurse for children looked after, an HIV support worker and a sexual health worker. This helps to ensure that young people understand their rights and entitlements well. Care leavers have a good understanding of their rights and responsibilities, and speak clearly about their entitlements. The booklet provided by the authority is well written and informative.

105. Young people are successfully encouraged to remain with their foster carers after they are 18. 'Staying put' arrangements are well managed and effective. This year, the proportion of care leavers who are remaining with their former foster carers is 34%, a significant increase on last year. Foster carers speak positively of these arrangements. All those who are currently caring for 17-

year-olds have plans for young people to remain in their care, post-18. However, a few care leavers spoke about delays of a couple of months in finalising the arrangements, which had left them uncertain about their futures.

106. The local authority is effective in ensuring that care leavers have positive destinations. Fifteen per cent of current care leavers are not in education, employment or training (NEET), a reduction from 25% last year. This is as a result of the work that the authority does overall to reduce the proportion of young people who are NEET, along with the work of personal advisors in individual cases. More than twice as many care leavers in Southend go on to further education as in similar local authorities or nationally. Thirty per cent of care leavers are currently in further or higher education, with 7% attending university. The local authority has worked successfully to increase the number of apprenticeships available for young people. There are now five within the authority and an additional four with partner agencies. However, the local authority does not track educational outcomes for care leavers sufficiently well to analyse their impact on young people or to monitor further progression.

107. Staff make sure that transitions for care leavers are smooth and effective. Handovers to the 16+ team are coordinated at young people's looked after reviews. Similar handovers occur when young people move from social workers to personal advisers. Transfer summaries are completed and the young people meet their new allocated social worker or personal advisor prior to transition, so that they know where to go for help and advice. Young people report that these transitions are seamless and that they move effectively into the next stages in their lives.

108. The local authority is effective in providing housing solutions for care leavers. As a result of good partnerships, the authority has put a range of options in place for young people, including supported accommodation and semi-independent living. Care leavers report favourably on the help and guidance that they receive to find independent accommodation, then to move in and live successfully. They feel safe where they live. The local authority has contingencies in place for tenancy breakdowns.

109. Eighty five of 92 care leavers, or 87%, are in suitable accommodation. Of those who are not, four are in custody. This improvement on the proportion last year, which was 80%, has been achieved through effective partnership work with local housing associations and young people's support organisations. The authority has not used bed and breakfast accommodation for the past six years. The use of houses in multiple occupancy is rare, and one young person is currently in emergency accommodation.

110. The local authority celebrates young people's success in a number of ways. For the past two years, most care leavers have attended the annual virtual school success celebration event, also attended by elected council members.

Leadership, management and governance	Requires improvement

Summary

Although managers have made some improvements in services over the past 18 months, the quality of services overall has not been maintained since the last inspection in 2012. The pace of improvement is too slow. Work undertaken with children who require adoption and with care leavers is good, and early help services continue to deliver strong provision, but services to children in need of help and protection and those who are looked after require significant improvement.

There are clear governance arrangements in place within the local authority and across the partnership. The local authority works well with strategic partners to commission and deliver services to meet areas of identified need. A fully integrated commissioning service has resulted in effective joint commissioning of a new emotional health and well-being service for children and young people.

The recent restructure of early help services has resulted in an integrated early help service that offers a wide range of good-quality support to children at all levels of need through a single 'front door'.

The local authority has worked well with partners to establish good strategic oversight of children at risk of sexual exploitation and those living in households where there is high-risk domestic abuse. However, these strategic developments have not yet resulted in consistently good-quality work with children, and there is a lack of direct oversight of practice at the frontline.

Performance information, quality assurance activity and the outcomes from peer reviews are not analysed or reported effectively to drive service improvement. While arrangements are in place for scrutiny by senior and political leaders, the quality of the information presented has not enabled them to have an accurate picture of the quality of work taking place with children in their service. As a result, scrutiny has not been effective.

The recording of work undertaken with children and families is not consistently of good quality. Families do not always receive reports or written information in a way that supports them to understand what the key issues of concern are. In many parts of the service, management oversight and decision making at all levels is not effective in ensuring the quality and timeliness of work with children, and the recording of decision making is not good.

Inspection findings

111. Since 2014, senior leaders have focused on working with partners on the further development of early help services to try to reduce the numbers of children and young people requiring statutory social work intervention. The local authority has worked with the pre-school learning alliance to develop the 'Better Start' initiative, funded by a £40 million grant from the Big Lottery Fund.

This is intended to transform how services during pregnancy and early childhood are delivered in specific communities across Southend, with the aim of delivering fully integrated community-based preventative services to over 4,000 children over the next 10 years.

112. In addition, existing early help provision has recently undergone restructure and integration, creating a coherent and effective early help service that delivers support across all levels of need accessed from a single 'front door'.

113. Since 2014, senior leaders have also undertaken work with the strategic partnership to challenge and support Essex police to address weaknesses in services affecting the ability of the local authority and wider partnership to keep children and young people safe. This has included establishing an appropriate strategic response to children at risk of sexual exploitation and those at risk from domestic abuse. Arrangements to respond to children at risk of sexual exploitation are now in place, but this has not yet been translated into consistent, good-quality frontline practice. In response to the lack of effective multi-agency arrangements to respond to high-risk domestic abuse, the local authority has led work with partners to implement new arrangements to ensure that effective information sharing and risk management is in place. This will be fully operational from June 2016, but progress on this has been too slow.

114. The joint strategic needs assessment provides a detailed overview of relevant data. This has informed the main themes and priorities in the children's and young people's plan, and has led to key service developments in early help and recommissioning of emotional health and well-being services. The health and well-being board, established in 2013, has been subject to a peer review. This has supported its recent development into a strategic forum that is now beginning to contribute to service development and improvement, including work to establish shared budgets to deliver integrated early help services.

115. There are clear lines of accountability across the strategic partnership, with a regular schedule of meetings and briefings to ensure effective communication between the chief executive, lead member and director of children's service (DCS). Quarterly meetings of the strategic safeguarding group enhance this further. This group, chaired by the chief executive, ensures that senior leaders, including the chair of the Local Safeguarding Children Board, clarify lines of responsibility across key safeguarding issues such as child sexual exploitation, children missing, domestic abuse and radicalisation.

116. Following a restructure in 2013, the corporate director for people holds the statutory role of DCS, in addition to the role of director of adult services. The council has ensured sufficient capacity by the creation of the post of head of children's services, reporting to the DCS and supported by four senior managers. In addition to a full test of assurance at the point of restructure, the council undertook a full review of that assurance in late 2014. This included seeking the views of key senior managers and, as a result, determined that the arrangements continued to be appropriate.

117. An established performance management framework provides regular reports to managers at all levels of the organisation to support service delivery. In some areas of practice, such as the timeliness of health assessments for children and young people, the scrutiny of this data has been effective in improving the service, but this has been slow. However, this inspection revealed that local authority data was inaccurate in two key areas. These relate to the time taken between child protection strategy meetings and initial case conferences, and the progress of cases in the public law outline process. As a result, poor performance in child protection work had not been identified. In other areas, such as the frequency of visits to children, managers have not analysed the reasons for inconsistent practice sufficiently, and so have not been effective in implementing measures to improve performance.

118. Quality assurance undertaken by the local authority identifies areas of poor practice and evidences some improvement over the past 18 months, with a reduction in examples of inadequate work and an increase in examples of practices that require improvement or are good. The pace of improvement is slow, and audits show that the majority of practice examined still requires improvement. Managers contracted by the local authority undertake the majority of audits in the programme. While this offers independent scrutiny, it has limited the potential for learning and the development of managers within the service.

119. Audit findings that are collated and reported regularly to managers and senior and political leaders do not provide sufficient analysis of areas of poor practice. They often contain narrative that does not accurately reflect audit findings. Reports do not clearly articulate the experiences of children. As a result, senior leaders lack an accurate understanding of the scale of improvement required in frontline practice. (Recommendation)

120. In many parts of the service, management oversight and decision making at all levels are not consistently effective, and records of decisions are poor. This results in children experiencing assessment and planning which are not of good enough quality. As a result, a small number of children receive a service at the wrong level of need, are referred and assessed too many times before intervention is effective, or experience delay in achieving permanence. In those services where practice is better, such as fostering, adoption and care leaver support, managers demonstrate stronger oversight and management 'grip', and this has resulted in the provision of good-quality services. (Recommendation)

121. The capacity of the independent reviewing service has increased. This has had a positive impact on the timeliness of reviews for children looked after. However, IROs do not always identify or challenge poor planning or delay, and so do not have enough impact on the quality and progress of care planning for children looked after or those in need of help and protection.

122. Senior leaders have recognised that case files do not contain good-quality and effective records of work with children that enable easy understanding or

evaluation of their story. While they have secured funding to procure and implement a new electronic system, they have not taken effective action to improve the way in which practitioners and managers record their work.

123. A detailed workforce strategy has helped to bring about a reduction in the turnover of frontline social workers and managers, with only five members of staff leaving the local authority in the last 12 months. The workforce strategy has supported effective recruitment of newly qualified staff, but does not fully address the challenges of recruiting experienced social work practitioners to ensure a balance of experience across frontline teams. There are mechanisms to restrict the volume of work allocated to newly qualified staff, but decisions about the complexity of the work allocated are the responsibility of the individual team manager. Some newly qualified staff work with children who are the subject of child protection plans or care proceedings. A clear evaluation of workers' ability and experience does not always inform allocation decisions. Inspectors saw examples of inexperienced staff having been given inappropriate responsibility for cases involving extremely complex situations and high levels of risk.

124. A revised and innovative supervision policy that more clearly separates casework supervision from developmental reflective management discussion was implemented in September 2015. Supervision takes place regularly, and social workers report that they feel supported and valued. However, casework supervision does not drive plans sufficiently quickly, and there is not yet consistent effective oversight of case planning or the delivery of a good standard of work to all children.

125. Elected member scrutiny of the work undertaken with children and families is not sufficient to ensure an accurate understanding or robust challenge to the quality of service that children receive. Regular headline performance data and annual reports presented to the bi-monthly 'people' scrutiny committee give an overview of key strategic issues, such as child sexual exploitation and domestic abuse, in addition to consideration of children who transition to adult services. However, information presented to members does not provide enough detail of performance, quality assurance or other independent reviews to give them a full picture of the quality of frontline practice experienced by children. (Recommendation)

126. The local authority is a committed corporate parent, and members of the corporate parenting group demonstrate knowledge and enthusiasm about services for children looked after. The regular review of performance information to identify areas for attention has resulted in successful focus in some areas, such as the completion of health assessments. Although there is a strategy for corporate parenting, the absence of a clear action plan with priorities and timescales limits the impact of the group. Members have some contact with children and young people, but there are no mechanisms in place to support children and young people to be directly involved or exert influence

on priorities. Although this is acknowledged as a gap, there are no plans in place to address this.

127. Southend has not yet embedded routine consultation and participation of children and young people in service development. There are examples of effective consultation to inform specific projects. However, the mechanisms needed to support children and young people, including those who are looked after, to share their experiences and exert influence are not in place, and require further development. (Recommendation)

128. An effective, integrated approach to commissioning involves the local authority and clinical commission group (CCG) working closely together to commission a range of services based on identified needs, and to review, revise and recommission services to improve quality. Work undertaken with neighbouring local authorities and CCGs has resulted in the recommissioning of emotional health and well-being services, based on need and on the feedback obtained from children and young people. These will deliver a range of integrated support and clinical intervention through a single point of contact.

129. Sufficiency of placements has been achieved primarily through the development of the local authority fostering service, supplemented by spot purchasing of agency placements when required, and a good range of placements is available for children. The local authority does not participate in regional placement arrangements, choosing instead to purchase placements as required, and to use its own dedicated resources to establish and monitor contracts and quality of provision.

130. Senior leaders express a commitment to delivering the best services possible for children in Southend and to collating learning from a range of sources, including serious case reviews and complaints. Where they have identified gaps in provision, they have arranged peer reviews or independent assessments to inform and support improvement. These have included work on child sexual exploitation, the health and well-being board and safeguarding.

131. While the local authority acknowledges learning points and recommendations from these external reviews, its response has not been robust enough to address the shortfalls identified in frontline services. It has not set out clearly enough the standards of practice that it expects, and the outcomes sought for all children and young people. As a result, action plans lack sufficient focus and the pace of change is too slow, with many areas of practice continuing to require improvement.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement

Executive summary

Southend Local Safeguarding Children Board (LSCB) has an experienced and well-respected chair who appropriately holds partners to account. Partnership and engagement on the board are strong. There is a shared ownership of safeguarding for children, and this is not seen as solely a local authority responsibility.

The LSCB has not effectively identified weaknesses in the application of thresholds. The threshold document is part of a wider early help practitioner toolkit, making it difficult to locate and understand. In terms of improving practice and outcomes for children, the LSCB's oversight is reactive rather than proactive. It has not done enough to show how the threshold pathway supports partners to escalate concerns.

There is a systemic weakness in the LSCB's structure. The multi-agency executive group does not include school representation, and the board does not have sufficient formal mechanisms in place to support the escalation of safeguarding concerns from the LSCB's schools and care provider forums. This leads to missed opportunities to explore these concerns and to identify any new safeguarding priorities.

A dependence upon the LSCB business manager to complete sub-group actions leads to delays in progressing some business plan priorities. The capacity of the LSCB and adult safeguarding board business team has recently been increased, but the full impact of this is yet to be seen.

The section 11 audit tool used across Southend and other local authorities in the region provides a consistent measure for agencies to self-assess their performance. The LSCB and chair robustly challenge agencies who do not submit a return, to ensure that all partners comply. However, the audits carried out in Southend had not identified all of the shortcomings found during the inspection.

The LSCB learning and improvement framework does not relate consistently to the training strategy, training programme and business plan priorities. Increased focus on expected learning outcomes and structured training programmes would support partners to identify training priorities more efficiently.

The LSCB is driving the implementation of an appropriate child sexual exploitation strategy and action plan. However, although multi-agency attendance at the sexual exploitation and missing children sub-group is consistently strong, the links between the sub-group and the missing and child sexual exploitation panel are not yet developed well enough.

Recommendations

132. The LSCB should take action to assure itself that thresholds are being appropriately applied across the partnership.

133. Ensure that education partners have their voice heard effectively on the executive board.

134. Clarify the governance role of the sexual exploitation and missing children sub-group, to align with other working groups in the local authority area.

135. Improve the learning and improvement framework and strategy and make sure that these link effectively to the business plan priorities.

Inspection findings – the Local Safeguarding Children Board

136. Southend LSCB has suitable governance arrangements in place, including the chair recently becoming a member of the health and well-being board. Meetings of the chair with the chief executive and the director for children's services, alongside quarterly oversight from the scrutiny panel, give rigour to the oversight of the work of the chair and the progress against LSCB business plan priorities. The LSCB appropriately holds the corporate parenting board to account, and seeks assurance from the community safety partnership about its role in helping and protecting children and young people. A strategic group of the chairs from the respective boards, chaired by the chief executive, now meets to discuss cross-cutting themes such as incidents of child sexual exploitation. This development has been appropriately influenced by the LSCB through the annual safeguarding report.

137. The LSCB has an experienced and longstanding chair, who is also the chair of the adult safeguarding board (ASB). The chair has built up significant relationships with all partners, and maintains effective independent oversight to ensure that the board meets statutory safeguarding responsibilities. Attendance at the board is consistently high, including the lead member for children's services. Partners are fully engaged and are committed to shared priorities for improvements in outcomes for children, both across the partnership and within their own service areas.

138. The current LSCB structure and processes do not enable all partners formally to influence and escalate safeguarding priorities to the board sufficiently. In particular, while the five LSCB sub-groups receive governance from the LSCB executive, a less structured, informal process is in place for safeguarding schools and care provider forums. Although both forums provide an arena for sharing safeguarding information and learning, the LSCB annual report does not identify its relationship with these forums, and the board induction pack does not identify them or the significance of their role in safeguarding children. This is a missed opportunity for sharing innovative practice and intelligence, and

further interrogation of partners' safeguarding concerns. For example, a request from a school for a risk assessment tool for children aged under 12 who may be at risk of child sexual exploitation was not progressed or escalated to the board.

139. In addition to the above, the LSCB multi-agency executive group, described as the engine room of the strategic board, does not have appropriate schools representation. This is a significant omission and weakness, given that the schools forum does not have formal links with the executive or board.

140. There is an over-reliance on the business manager, who is also the business manager for the ASB, to progress actions from the sub-groups. The board has recently recognised this lack of capacity, and has agreed to invest in a new data and performance post to support both the LSCB and ASB. This recent change has not yet had an impact upon the progress of work.

141. There is robust critical challenge across the partnership, including from layperson representatives, and a commitment to effective monitoring of frontline practice. When deficits are identified, the LSCB engages partners and proactively coordinates actions to implement change. There are examples where this has resulted in positive change to services delivered for children and young people. These include the refurbishment of interview suites for children and young people who have been abused, and improvements to the resource centre pathway for victims of sexual abuse.

142. The LSCB has been responsive to concerns identified by partners regarding thresholds, undertaking bespoke audits to complement the existing quality assurance framework and pre-planned audit activity. These have included analysis of the effectiveness of the audit tool. A recent challenge from partners to perceived threshold changes prompted an intuitive and practical response from the LSCB monitoring sub-group. It undertook an audit which concluded that the quality of contact information required improvement to ensure an appropriate response to the contacts received.

143. However, the board is not using multi-agency audit activity and performance data well enough to achieve effective oversight of frontline practice and to test the effectiveness of thresholds across the partnership. It has not been sufficiently rigorous in its understanding of how thresholds are applied, limiting its ability to challenge poor practice and implement change.

144. The threshold document is not easy to understand, as it uses different terminology to describe stages of need across the partnership and identifies a complex threshold matrix of services that are available. Held within the early help toolkit, the threshold pathway is neither easy to locate nor clearly identifiable on the LSCB website. It does not support partners in understanding thresholds well enough to escalate concerns, as transition from one stage to another is not sufficiently clear. Partners providing services across the region find the differences in terminology between Southend and other local authorities to be unhelpful.

145. In July 2014, the LSCB identified early concerns about delays in assessing risks to children living with domestic abuse. A multi-agency audit and report on domestic abuse presented to the board in March 2015 identified continued delays in notifications and referrals to children's social care. A new multi-agency risk assessment team (MARAT) was implemented in April 2016 to respond to and protect children living in high-risk domestic abuse situations. It is too soon to see any impact by this new initiative on the weaknesses in this area of work that were seen in the inspection of the local authority.

146. The LSCB's oversight of the child sexual exploitation strategy and action plan is underdeveloped. The relationship between the missing and child sexual exploitation panel and the LSCB sexual exploitation and missing children sub-group needs to be strengthened. This is to improve information sharing between partners and to prevent duplication of effort.

147. The board is proactive in raising awareness of child sexual exploitation risks, and the links to children missing from home and school. Multi-agency training opportunities and strategic safeguarding meetings are beginning to develop expertise across the partnership. Cross-cutting priorities for both the LSCB and ASB have been recognised in the alignment of planning for children and young people identified as at risk of child sexual exploitation, who may become vulnerable adults at risk of further exploitation at 18. The LSCB annual report for 2014–15 identifies over 385 champions to counter child sexual exploitation across Southend, reporting to the sexual exploitation and missing children sub-group. The champions have promoted the toolkit across the localities, leading to an increase in awareness and a rise in referrals for children identified at potential risk of exploitation. The LSCB's online awareness training to combat child sexual exploitation has been accessed by over 500 professionals from a wide range of partner agencies.

148. The LSCB monitoring sub-group has initiated partnership working with clinical commissioning groups to develop general practitioner (GP) forums. These identify safeguarding training needs and share learning, for example about female genital mutilation. An online awareness-raising training programme is available, and all GPs are registered on a mandatory reporting system. Following presentations from early years workers on the 'Better Start' initiative, all but five GPs are now registered with this system, designed to improve information sharing.

149. LSCB partners reach a wide range of children and young people through initiatives to support their health, welfare and development, build resilience and learn how to keep themselves safe. A drama production on teenager abuse has reached 800 children and young people. Four thousand children attended a 'Walk Online' roadshow that provided a range of advice on e-safety. Children's feedback was that those attending are more conscious of privacy settings on social media and of reporting mechanisms for nuisance and abusive contacts. Positive impact included further training needs on e-safety being identified for

professionals. One thousand children and young people participated in an equality and diversity programme focused on bullying.

150. Compliance with section 11 audits is high, and the LSCB evaluates local performance to influence and inform the planning and delivery of services effectively. The audit tool used across Southend and other local authorities in the region provides a consistent measure for agencies to self-assess their performance. The LSCB executive reviews the collation of returns and submits an annual report to the LSCB. It robustly challenges agencies who have not made a submission, to ensure that all partners comply with their safeguarding responsibilities. This includes appropriate direct challenge from the chair. However, the audits carried out in Southend had not identified all of the relevant shortcomings found during the inspection.

151. The LSCB learning and improvement framework is simplistic. Measurements of impact and outcomes of training are the same across different training elements, with no bespoke learning outcomes for partners to understand how learning will be used to support practice. There are no timescales given, and the framework does not provide an obvious link to the priorities identified in the business plan. The board's training strategy document does not identify clear plans for training. The associated training programme is not well organised, with no list of contents or page numbers. This is not helpful for partners, and does not enable them to identify quickly which level of safeguarding training is required for staff and managers. There is a lack of focus on what the strategy is trying to achieve, no clear recommendations of appropriate training for partners, and no obvious link between the strategy and training programme.

152. The LSCB learning and development sub-group rigorously monitors the quality and quantity of feedback from partners' attendance at training, and pursues partners who do not submit returns. Evaluations completed both during training and at a six-week follow up reflect how training is being used to improve operational practice. For example, partners report more understanding of the child protection process to support families and greater confidence in expressing their views at child protection case conferences. Training is flexible, in accordance with identified learning needs, and is developed for frontline staff through the board's audit programmes. There is a 96% attendance rate on safeguarding training, demonstrating partner commitment and engagement.

153. The LSCB website is underdeveloped and not accessible to children and families. It does not have easy-to-understand information that would support children's and families' engagement or help them to understand how to access help. There is no facility for comments or feedback specifically from children and young people, to help to inform practice and developments, implement change or monitor improvements.

154. Not all frontline staff are sufficiently aware of the role and influence of the LSCB, or of the learning it disseminates. The board does not have a sufficiently high profile as the coordinator of safeguarding practice and the driver of

developments. This reduces opportunities for influencing change as a partnership. The thematic briefing on learning from serious case reviews presented to the board in September 2015 does not demonstrate how the impact of this learning is measured. Therefore, the LSCB cannot be assured that learning from serious case reviews is either effective or used to improve practice. A practitioner event on the theme of neglect has been postponed from October 2015, so learning for staff has not been disseminated.

155. The LSCB completed one serious case review during the period 2014–15. Advice was appropriately sought from the national SCR panel, which agreed that the review should not be published, in order to protect a surviving family member's identity.

156. The chair of the LSCB community sub-group is also the LSCB representative on the sub-regional child death overview panel. This provides an efficient process for information sharing and identification of safeguarding concerns across the sub-region. This has appropriately informed an LSCB priority to increase awareness and understanding of the high proportion of adolescents who self-harm, in order to inform partners' safeguarding responsibilities. However, progress in developing intelligence and data on this priority has been slow.

157. The LSCB annual report 2014–15 provides a suitable analysis of activity throughout the year, including setting out clear priorities and desired improvements to safeguarding services for children and families. This includes oversight and appropriate monitoring of the effectiveness of early help support, utilising the early help quality assurance framework effectively.

158. The LSCB scrutinises effectively the annual report of the local area designated officer about allegations against staff. The identification of a lack of referrals from health partners prompted the initiation of additional training for health staff.

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 eight of Her Majesty's Inspectors (HMI) from Ofsted and one additional inspector (AI).

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