Metropolitan Borough of Solihull

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

Report published: 7 July 2016

Children's services in Solihull 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	Requires improvement
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

The local authority is ambitious. Knowledgeable and experienced senior managers and leaders are working well together to manage change in a systematic way. Beginning with the restructuring of children's social care services, they have established a multi-agency safeguarding hub (MASH) and are now rolling out the new early help offer. Firm foundations have been laid. Good progress is being made. Improvement is continuing.

However, children are not yet being consistently well served. While inspectors did not identify any children at immediate risk of significant harm, it is evident that some children have experienced, and continue to experience, drift and delay. The development of a robust performance culture is still a work in progress. The level of frontline management oversight is not consistently rigorous or robust. The challenge is to develop a greater sense of urgency and a more ruthless focus on core practice, in order to improve outcomes for children and young people.

Children, young people and families are able to access a good range of services to counter substance misuse and domestic violence, and promote emotional well-being and mental health. These have been reconfigured and recommissioned to extend their reach and effectiveness. Early help is being strengthened to ensure that those families that require a more structured response, based on a holistic assessment of their needs, are able to the get the early help and support that they need from groups of professionals working together as a team around the family.

The new MASH arrangements are working well. A good understanding of the thresholds for access to children's social care services ensures that most referrals are appropriate. In almost every case, referrals lead to a suitable and timely service response. The local authority is taking action to ensure that the issue of parental consent is fully explored and well recorded.

Strategy meetings organised in the MASH are good, and are used effectively to shape subsequent action. Away from the MASH, the involvement of partner agencies and their contribution to strategy discussions are not consistently reliable or robust. The timeliness of child protection conferences has improved, but core groups are not always sufficiently rigorous in tracking and reviewing progress.

The quality of chronologies and the timeliness of assessments have improved. In most cases, the voice of the child is clear and well recorded. However, the quality of assessments and plans is variable, ranging from good to requires improvement. On occasion, this contributes to a lack of focus and/or drift and delay, for some children.

Strategic and operational responses to child sexual exploitation and children who go missing from home, school or care are well developed and well managed. However, there is still room for improvement, for example in ensuring that the quality of return home interviews is of a consistently high standard. The local authority has responded well to the threat of radicalisation.

Decisions that lead to children and young people becoming looked after are appropriate, although the Public Law Outline is not always being used effectively. Most children and young people looked after live with foster carers in stable and settled placements. Good attention is paid to their emotional well-being, as well as to their physical health, including those who are living out of borough. The virtual school is becoming increasingly effective in monitoring the progress and achievement of school-aged children, all of whom have up-to-date personal education plans. Currently, 80% of children and young people looked after attend a good or better school.

In the last 12 months, frequent changes of personnel have impacted on the ability of children, young people and their carers to build and sustain meaningful relationships with their social workers. In some cases, lack of continuity has contributed to drift and delay. Most looked after reviews are timely, with good input from children and young people. However, the reviews are not always effective in ensuring that issues and concerns identified are quickly resolved.

Even allowing for the large number of asylum-seeking children in Solihull because of the presence of the UK Border Agency's immigration enforcement unit, the number of children looked after is disproportionately high for a local authority of its size. Until recently, the local authority has been sluggish in its approach to achieving permanence for children, other than through adoption. The recruitment of foster carers is not well targeted to ensure that there is a sufficient supply of foster carers to meet current and future demand.

Adoption is routinely considered for all children at an early stage, and adoption performance is good. Family-finding strategies are increasingly effective. Adoptive parents are appreciative of the preparation, training and support that they receive. Inspectors saw some excellent examples of life-story work.

Most care leavers live in suitable accommodation, have clear, comprehensive and appropriately ambitious pathway plans, and are well supported to develop their independent living skills. The percentage of care leavers in education, training and employment has increased. However, more could be done to engage, support and safeguard the most vulnerable.

The local authority takes its corporate parenting responsibilities seriously, as evidenced by the impact and effectiveness of the corporate parenting board. Learning from complaints is used well to improve practice. However, the Children in Care Council has been allowed to stagnate. The local authority has not organised any celebratory events for children looked after or care leavers in the last 12 months.

Following the upheaval caused by the restructuring last year of children's social care services, the rate of staff turnover has fallen significantly. With manageable caseloads and good support for newly qualified social workers, there are signs that it is becoming easier to recruit and retain staff.

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 January 2012. The local authority was judged to be adequate.
- The last inspection of the local authority's services for children looked after was in January 2012. The local authority was judged to be adequate.

Local leadership

- The director of children's services has been in post since February 2014.
- The chair of the LSCB has been in post since August 2014.
- The local authority has not delegated any functions to a social work provider.

The model of social work practice used in this local authority is 'signs of safety'.

[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.

Children living in this area

- Approximately 45,437 children and young people under the age of 18 years live in Solihull. This is 21.6% of the total population in the area.
- Approximately 15% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
    - in primary schools is 13.3% (the national average is 15.6%)
    - in secondary schools is 12.1% (the national average is 13.9%).
- Children and young people from minority ethnic groups account for 17.1% of all children living in the area, compared with 21.5% in the country as a whole.
- The largest minority ethnic group of children and young people in the area is Asian or Asian British.
- The proportion of children and young people who speak English as an additional language:
    - in primary schools is 6.8% (the national average is 19.4%)
    - in secondary schools is 5.5% (the national average is 15.0%).

Child protection in this area

- At 31 March 2016, 1,324 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 1,349 at 31 March 2015.
- At 31 March 2016 (provisional year end data), 206 children and young people were the subject of a child protection plan. This is a reduction from 218 at 31 March 2015.
- At 31 March 2016, two children lived in a privately arranged foster placement. This is a reduction from four at 31 March 2015.
- Since the last inspection, six serious incident notifications have been submitted to Ofsted and three of these are now serious case reviews that have been completed or are ongoing at the time of the inspection.

Children looked after in this area

- At 31 March 2016, 360 children (provisional year end data) are being looked after by the local authority (a rate of 79.8 per 10,000 children). This is an increase from 335 (74.0 per 10,000 children) at 31 March 2015. Of this number:
    - 205 (or 57%) live outside the local authority area
    - 20 (or 5%) live in residential children's homes, all of whom live outside the authority area

- none live in residential special schools[3]
- 269 live with foster families, of whom 57% live outside the authority area
- 35 live with parents, of whom 5 live outside the authority area
- 67 children are unaccompanied asylum-seeking children.

- In the last 12 months:
  - there have been 12 adoptions
  - four children became subject of special guardianship orders
  - 128 children ceased to be looked after, of whom 4% subsequently returned to be looked after
  - 33 children and young people ceased to be looked after and moved on to independent living
  - 16 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. Ensure that the performance management framework provides middle and senior managers with a clear line of sight on those issues and areas that matter most, including, for example, the frequency and quality of supervision and key aspects of frontline practice.

2. Ensure that the level of critical challenge provided by front line managers, child protection conference chairs and independent reviewing officers is consistently rigorous and robust and that, once escalated, concerns are dealt with quickly and effectively.

3. Ensure that the quality and effectiveness of assessments and care plans are of a consistently high standard, and are regularly reviewed and updated.

4. Ensure that strategy discussions and core groups are consistently effective as forums for sharing information, identifying risks and prompting appropriate action.

5. Ensure that decisions taken by and action agreed at multi-agency sexual exploitation meetings are simply and clearly recorded, then routinely followed up from one meeting to the next.

6. Ensure that the local authority designated officer is provided with an effective system for monitoring and recording allegations, one which facilitates external scrutiny.

7. Ensure that effective use is made of the Public Law Outline to avoid drift and delay and, where appropriate, systematically to explore alternative family-based solutions for children who are unable to continue to live safely at home, including through the use of consistently high-quality viability assessments.

8. Ensure that all children and young people who are looked after have plans that clearly and explicitly address their need for permanence.

9. Ensure that the foster carer recruitment strategy includes specific targets and actions. These are to increase the range and availability of placement options to meet the assessed needs of different groups of children and young people, now and in the future.

10. Ensure that appropriate action is taken to increase the range and volume of suitable accommodation for care leavers in order to reduce the reliance on houses in multiple occupation.

11. Ensure that the Children in Care Council is properly supported, to enable it to reach out to and represent the views of children and young people looked after and care leavers.

Summary for children and young people

- The council and its partners are taking action to improve how children and families get the help and support that they need as early as possible.
- Schools work well to try to make sure that children and families get the help that they need quickly.
- Adults in the borough work well together to try to ensure that children are safe from harm.
- Some children have had lots of different social workers, which makes it hard for them to get to know and trust their social workers.
- The council and frontline managers need to work even harder to make sure that every child or young person gets the best possible service.
- Most children and young people who are not able to live with their own families are living with foster carers.
- The council needs to do more work to make sure that it has the right kind of foster carers for children, when children need them.
- When it is not safe for children and young people to go home, the council and social workers need to improve the way that they write plans so that children understand what is happening in their lives.
- The council is getting better at finding families quickly for children who need to move to a new and permanent family.
- The council is also getting better at making it possible for young people in care to stay with their foster families when they reach 18, if they want to.
- When the time comes for young people to leave care, most of them get good help and support to prepare them for independence.
- A lot of young people who used to be in care are now going to college or university, and get the support that they need to do this.
- In the last 12 months, the Children in Care Council has not been given enough support or attention.

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

Summary

Children and families are able to access early help and support but, until recently, not in a well-coordinated way, based on the outcome of an early help assessment or delivered by agencies working together as a team around the family. A new early help offer is being rolled out, but the level of management oversight is not yet sufficiently robust.

The good understanding of the thresholds for access to children's social care services means that most referrals are appropriate and timely. The multi-agency safeguarding hub (MASH) ensures that referrals are thoroughly assessed and lead to an appropriate service response. Consent is routinely sought, but is not always well recorded. Professionals are able to get advice and guidance from social workers based in the MASH, and are given feedback on the progress of referrals.

Strategy meetings held in the MASH are used effectively to share information. Timely decisions result in appropriate action being taken to manage or minimise risks. Away from the MASH, the contribution of partner agencies to strategy meetings is less reliable. This has the potential to undermine the effectiveness of strategy meetings and the action resulting from them. However, inspectors did not identify any children who were at immediate risk of significant harm as a result.

Most assessments require improvement, although the voice of children is clear in most cases. While the quality of chronologies has improved significantly, some assessments lack analysis and fail to take full account of the historical context. Children in need plans are not always regularly updated. This applies particularly to children who have disabilities.

The timeliness of child protection conferences is improving. Information is shared effectively, and partner agencies work well together to safeguard and protect children. Child protection plans are outcome focused, specific and measurable. However, child protection conference chairs do not consistently provide the right level of critical challenge and core groups are not always effective in rigorously monitoring progress. The quality and effectiveness of frontline management oversight and scrutiny require improvement to prevent drift and delay.

Work with children and young people at risk of child sexual exploitation and those who go missing is making a positive difference. Return home interviews are routinely offered, although it is not always clear how the information is used to safeguard and protect children. The local authority has a good understanding of the 'Prevent' agenda.

Inspection findings

12. Although children and families are able to access a good range of supportive early help services, very few receive support based on a holistic assessment of their needs, provided by professionals from different agencies working together as a team around the family. The local authority is rolling out its new early help strategy, which has been developed in consultation with partner agencies. This is intended to bring together the work of the troubled families team, youth services, specialist careers service, educational welfare and children's centres in the new 'Engage' service. Performance management and quality assurance systems are a work in progress. As yet, the number of early help assessments (EHAs), which have replaced the common assessment framework, have not increased significantly. Although the initial feedback from professionals is positive, the local authority is not yet in a position to monitor the progress or evaluate the impact of the new EHAs.

13. The establishment of the multi-agency safeguarding hub (MASH) is making a positive difference to children and families. With robust management oversight at every stage, workflows are managed effectively. Professionals are able to consult social workers based in the MASH, and receive sound advice and guidance from them. Thresholds for access to children's social care services are generally well understood by partners, and are applied consistently by staff and managers based in the MASH. Most referrals are relevant and appropriate. In the last quarter, only 4% resulted in no further action. When necessary, visits are made, usually on the same day as the referral, to check that thresholds are met and to determine the next steps. This is good practice. It helps to avoid drift, and ensures that decisions are timely and well informed.

14. Strategy meetings organised by the MASH are well chaired and well attended by partner agencies. Effective information sharing means that the help and protection that children receive are proportionate to risk. However, once cases transfer from the MASH, strategy meetings are not consistently effective. Health, education and police partners do not routinely attend or contribute. This means that, in some cases, valuable and important information is not captured or used to inform decision making.

15. Child protection enquiries are thorough and timely. Decisions to carry out joint- or single-agency investigations are appropriate. Partner agencies contribute well to child protection enquiries and to a shared understanding of the risks.

16. The emergency duty team (EDT) provides an effective level of support to safeguard children out of hours. Its response to unaccompanied asylum-seeking children is particularly good. Good two-way communication with day-time colleagues ensures that the service offered is seamless.

17. The quality of social work assessments, including pre-birth assessments, is variable, ranging from requires improvement to good. Good assessments are informed by research, influenced by the child's wishes and feelings, and result in clear and appropriate recommendations based on good understanding and analysis of the child's need and circumstances. Weaker assessments, some of which take too long to complete, are limited in the depth and breadth of their understanding, particularly of the historical context, and are short on analysis. A lack of consistently robust management oversight means that the poor quality of some assessments is not always identified or challenged by those who are responsible for signing them off. As well as doing a disservice to children and families, this denies social workers an opportunity to improve their practice. The timeliness of assessments has improved. The quality of chronologies has also improved. Inspectors saw very few case records without an up-to-date assessment, and chronologies are now being used more consistently by social workers to inform their analysis and decisions. This is making a positive difference. (Recommendations 2 and 3)

18. The timeliness of initial and review child protection conferences is improving. Most child protection plans seen are good. They are outcome focused, specific and measurable. However, a failure to focus consistently on progress against the actions set out in child protection plans means that core groups are not always effective in tracking and driving change. Currently, managers are not required to authorise or sign off core group minutes. Additionally, the challenge offered by child protection chairs is not always sufficiently robust. Lack of management oversight and challenge contributes to drift for some children. (Recommendations 2 and 4)

19. The pre-proceedings protocol is not being implemented soon enough, in some cases. By not using family group conferences to explore family-based solutions, including alternative care arrangements for children, the local authority is missing a valuable opportunity. (Recommendation 7)

20. The local authority has plans to adopt the graded care profile to assist social workers and partner agencies in identifying and working with neglect. The local authority has also introduced a recognised strengths-based and safety-focused social work model to help families to develop a better understanding of what it is that professionals are concerned about. This is having a positive impact, resulting in a 55-strong reduction in the number of children who are subject to child protection plans because of neglect.

21. Children are seen alone by social workers, who work hard to build effective relationships with them. Inspectors saw some good examples of direct work with children by social workers or family support workers, and of direct work being used well to influence and inform assessments and plans. Staff in the children with disabilities team are particularly good at engaging and working with children. However, while there is an expectation that children who are subject to child protection plans should be visited at least every 28 days, and

more frequently where the assessment indicates that this is necessary, child protection plans do not routinely stipulate the frequency of visits. This also applies to child in need plans and means that the pattern and frequency of visits are not always proportionate to the child's circumstances or the level of risk.

22. The quality of child in need plans seen by inspectors in the children in need team is good. Clear, outcome focused, regularly reviewed and updated, they accurately reflect changing circumstances and risks, resulting in cases being stepped up or stepped down appropriately. However, a shortfall in staffing and management capacity in the children with disabilities team means that most child in need plans are not being reviewed or updated in a timely way. This means that the local authority cannot be confident that the needs of children who have disabilities are being well met.

23. Good systems and processes enable homeless 16- and 17-year-olds to make informed decisions about whether to accept help and support as children in need or as children looked after. When young people present as homeless, their needs are thoroughly assessed by a qualified social worker, with support from a housing officer.

24. Services work well together to support children and young people who are affected by parental mental ill health, substance misuse and/or domestic abuse. Social work assessments show good awareness of the impact on children of one or more of these issues. Domestic abuse services routinely complete assessments and safety plans for women and children. The local authority has recently invested in a post to focus specifically on domestic abuse in teenage relationships.

25. The multi-agency risk assessment conference (MARAC) is in need of an injection of new life. In 2015–16, the number of referrals to the MARAC fell. Only 10% came from agencies other than the police. Senior officers have plans to revitalise the MARAC and are taking action to increase awareness and understanding of its important role across the partnership.

26. With a good understanding of child sexual exploitation and the risks associated with children going missing, the local authority and its partners have put in place effective systems, structures, policies and procedures to manage and support this vulnerable group of children and young people. The operational group that manages and deals with cases of child sexual exploitation and missing (CMOG) is an effective forum. Focusing on young people who are considered to be at high risk of child sexual exploitation, it enables partners to share information and use intelligence to inform disruption activity. Children who go missing and/or for whom the risk of sexual exploitation is less acute are regularly discussed at multi-agency sexual exploitation meetings. However, while these meetings are well attended and information is shared effectively, actions agreed are not consistently well recorded or followed up from one meeting to the next.

Additionally, although child sexual exploitation screening tools are routinely completed and the level of risk identified accurately, matching concerns in almost all cases, the resulting action plans are not always sufficiently outcome focused. Timescales for reviewing progress are not always clear. (Recommendation 5)

27. A small but effective specialist team works directly with young people who are at risk of, or are being, sexually exploited. Referrals are accepted promptly. There is no waiting list. The support that the team is able to offer has recently been supplemented by a range of therapeutic interventions. These are available through the recommissioned emotional well-being and mental health service, Solar. It is too early to evaluate the impact of this development.

28. Children who go missing are routinely offered return home interviews, most of which are carried out within 72 hours. However, the records of the interviews are not consistently uploaded to children's electronic case records and the information they generate is not always being used effectively to inform care planning.

29. The local authority has responded well to the challenges associated with radicalisation. Although the level of risk in Solihull has been assessed as being relatively low, the fact that circa 7,000 students travel into Solihull schools and colleges each day from neighbouring authorities means that there is no room for complacency. Robust governance arrangements, high levels of awareness and well-developed referral pathways around radicalisation mean that, while the number of referrals remains low, Solihull is well prepared. The 'Prevent' board is well attended by schools, colleges and independent education providers, the fire brigade, probation service, police (including counter-terrorism police) and health services. Schools understand the referral pathways and consult appropriately. Thirty-four concerns were raised by schools in the last 12 months and two children were referred to the Channel panel. To date, 4,699 of the 7,000 school and college staff, including lunchtime supervisors, have received training in Working together to raise awareness of the 'Prevent' strategy (WRAP), and 91 of the 93 educational establishments in Solihull have a WRAP trainer.

30. Almost all of the young people who are currently in alternative educational provision receive 25 hours of tuition per week. The small number who do not are well supported by professionals, including educational psychologists. Those who receive home tuition for medical reasons, many of them with emotional well-being and mental health issues, are closely monitored. The Triple Crown Centre, which is part of the pupil referral unit, caters specifically for young people with medical conditions.

31. The missing education service is meticulous in the way in which it carries out its responsibilities. By July 2015, it had successfully tracked all but two of the 1,400 pupils whose names had been removed in-year from school rolls

without a known destination. Mindful of the need to ensure that children attend registered schools, the service is equally thorough in tracking children of school age who have not applied for a school place. Any concerns about children's safety are referred to the MASH.

32. The elective home education service is careful and conscientious in developing supportive relationships with parents, assessing the quality of the education provided and taking appropriate action when it does not meet the required standard. Parents are signposted to services and resources that could be useful to them. At the time of this inspection, 102 children and young people are being electively home educated.

33. Private fostering does not receive the attention that it requires. Currently, only two children are known to be living in a private fostering arrangement. When children are identified, they are visited promptly, in line with statutory guidance. However, more needs to be done to raise awareness of private fostering in order to ensure that children who are living informally with people to whom they are not related are properly safeguarded.

34. When allegations about adults in positions of trust are made, appropriate action is taken to safeguard and protect children. Information is shared well with the MASH. Decision making is timely. However, the lack of a customised system for recording and monitoring allegations makes it difficult for the local authority designated officer to track the progress of cases and limits the effectiveness of external scrutiny. (Recommendation 6)

35. Senior leaders and managers do not routinely invite feedback from children and young people about their experiences of, or their views on, the quality and impact of the help, protection and support that they receive. However, plans are underway to introduce a feedback survey for young people who are, or who have been, subject to child protection plans.

36. A growing number of children and young people are making use of the independent advocacy service to enhance their participation in, and contribution to, child protection conferences. Effective advocacy support is provided to parents to ensure that their views are fully represented in child protection conferences.

37. Staff in the team for children with disabilities are resourceful and imaginative in finding different ways to communicate with children who are not able to express themselves verbally. Inspectors also saw some good examples involving the use of interpreters for children and families who speak English as an additional language. More generally, while social workers routinely record the ethnicity of children and young people, they do not consistently ensure that assessments are sensitive and responsive to the differences that reflect the unique identity of each child or young person. This applies particularly to White British children.

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

Summary

Although most children come into care in an unplanned way, inspectors found no evidence of children becoming looked after who should not have been. The local authority's response to asylum-seeking children is timely and effective. The quality of evidence and plans presented in court has improved and, as a result, the average length of care proceedings is being reduced. However, the Public Law Outline (PLO) is not consistently being used to best effect and there is room for improvement in the quality of viability assessments.

Most children live in settled and stable foster placements. Good attention is paid to their health, including their emotional health and well-being. Children know how to complain. When they do, their complaints are taken seriously. However, until recently, a high turnover of staff has made it difficult for some children to build and maintain meaningful relationships with their social workers. Although the timeliness of reviews is good, some children have experienced drift and delay because of a lack of consistent critical challenge and/or rigorous attention to detail on the part of some front line managers and independent reviewing officers. The quality of assessments and care plans requires improvement. The local authority is now taking appropriate action to ensure a more proactive approach to achieving permanence for children for whom adoption is not the right solution.

All children have personal education plans that are regularly reviewed and updated. Currently, 80% of children attend a good or better school. At key stages 1 and 2, the attainment gap between children looked after and their peers is narrowing. The virtual school is becoming increasingly effective.

The local authority and its partners have a good grasp of the issue of sexual exploitation. When children go missing from care, they are routinely offered return home interviews, but further work is required to ensure that they are of a consistently high standard.

As a result of all the other changes that have been going on in the last 12 months, the Children in Care Council has not received the attention that it deserves. Its members feel disappointed and disillusioned.

Adoption performance is good, overall. Adoption is considered for all children at an early stage. Family-finding strategies are increasingly effective. Adoptive parents talk very positively about the preparation, training and support that they receive, both before and after adoption. Life-story work is a real strength.

Most care leavers live in suitable accommodation, and are encouraged and supported well to take part in education, employment or training. However, more could be done to engage, support and safeguard the most vulnerable.

Inspection findings

38. Children only become looked after when it is right that they should be. The majority of the 10 most recent admissions to care have involved children who became looked after either in an emergency or at a time of crisis. The rate of children looked after is higher than in Solihull's statistical neighbours. Despite these factors, inspectors saw no evidence of children becoming looked after inappropriately.

39. The local authority has responded well to the challenges posed by a steady increase in the number of unaccompanied asylum-seeking children. Immediate action is taken to safeguard and protect them. Arrangements to assess and accommodate them, identify their immediate needs and organise initial health assessments are well managed. At the time of this inspection, unaccompanied asylum-seeking children and young people accounted for 19% of the children looked after population (67 out of 358).

40. The local authority is taking action to make better use of the PLO, either to achieve meaningful change in families when risks and concerns increase, or to make plans for children to live permanently away from home. Where the PLO has been used well, parents clearly understand the issues and concerns, and what is expected of them. Some parents have successfully managed to make the necessary changes and, in doing so, avoided the need for legal intervention. However, a lack of effective management oversight means that decision making is not always timely. Inspectors saw some evidence of delay in sending PLO letters and written agreements, and/or in initiating care proceedings. During the inspection, the local authority introduced a simple but effective PLO case-tracking tool. (Recommendation 7)

41. In some cases, viability assessments are being used proactively to identify whether other family members are able to care for children when it is apparent that it is not safe for children to continue to live with their birth families. However, the quality of viability assessments is variable. In some cases, certain relatives remain to be considered or are ruled out quickly and effectively. Inspectors also saw examples where significant risks had been identified, but decisions were deferred until the second stage of the assessment process. This has the potential to blur permanency planning and contribute to delay. (Recommendation 7)

42. A significant reduction in the average duration of care proceedings means that children and young people are not waiting as long for important decisions to be made about them. The timeliness of proceedings has improved, down from 37 to 33 weeks. The local authority's latest unvalidated data shows further improvement, with care proceedings now taking, on average, 28 weeks to complete. Currently, 30 cases involving 59 children and young people are before the courts, 23 of which are on track to be concluded within 26 weeks. There are good reasons why the seven remaining cases will take longer. The Children and Family Court Advisory and

Support Service and the judiciary talks positively about the improved quality of the assessments, evidence and plans that are presented in court.

43. The majority of children benefit from settled, stable, foster placements. Most children are seen regularly by their social workers, who know them well. However, in the last 12 months some children have experienced repeated changes of social workers. This makes it difficult for them to establish and maintain positive relationships with their social workers, and causes frustration for them and their foster carers. One child told his foster carer that he could not 'see the point in having a social worker'.

44. Children and young people know how to complain. When they do, their complaints are taken seriously. As evidence, for example, a social worker was changed after a child had complained. Children, including those who have disabilities, make good use of the advocacy service to raise concerns or issues, and/or support them in influencing key meetings and decisions that affect their lives. However, limited capacity means that, at present, relatively few children are benefiting from an independent visitor.

45. The local authority's response to children who go missing and/or are at risk of child sexual exploitation is thorough and consistently applied, in most cases. Foster carers and residential staff are clear about their responsibilities to safeguard and protect children, and raise an immediate alert when children go missing. Inspectors saw evidence of carers searching actively for missing children, rather than just leaving the police to do so. In the third quarter of 2015–16, there were 34 reported episodes of children looked after going missing. These relate to 15 young people, five of whom had been assessed as being at risk of child sexual exploitation.

46. When children go missing from care, the quality of the information provided by return home interviews (RHIs) largely depends on who completes the interview. The majority, which are completed by the independent advocacy service, are thorough and detailed. The local authority analyses RHIs to identify patterns and themes in order to strengthen their protective responses. However, the variable quality of RHIs and the failure to capture the reasons given by young people for refusing interviews limit the effectiveness of this approach.

47. The local authority takes very seriously its responsibility to promote the health and well-being of children looked after. It has taken concerted action to make sure that health checks are timely. Unaccompanied asylum-seeking children are fast-tracked for initial health assessments and immunisations. Children looked after are seen regularly by dentists and opticians, and 97% of annual health assessments are completed on time. Children looked after have ready access to specialist support around substance and alcohol misuse, contraception, sexual health and teenage pregnancy. Good use is made of strengths and difficulties questionnaire scores to identify children looked after who would benefit from a referral to the recently

recommissioned emotional well-being and mental health service, Solar. The designated nurse for children looked after leads on all health assessments for children looked after who are living within a 50-mile radius of Solihull, ensuring that their health needs are met.

48. Currently, 80% of children looked after attend good or better schools. A number of other children attend schools which, as recent academy conversions, do not have a current Ofsted judgement. Where a child is at a school judged as less than good, the local authority endeavours to mitigate any possible adverse impact through its rigorous approach to personal education plans. Schools now complete personal education plans (PEPs) themselves. PEPs, which are reviewed every term, are mostly evaluative. They identify clear and measurable actions for improvement and focus well on the effective use of pupil premium funding. All children and young people of statutory school age have a PEP, although post-16 institutions have been slow to ensure that plans are in place for all young people.

49. Children looked after do well at primary school, but less well at secondary school. At key stages 1 and 2, their attainment in reading, writing and mathematics has been consistently at least as good as, and mostly better than, the average for children looked after nationally. Most children looked after make expected or better progress at key stage 2 than their attainment at key stage 1, and the attainment gap between them and other pupils in the borough is narrowing. However, in 2015, the overall attainment of children looked after at key stage 4 dipped sharply, with a third making low levels of progress in English and a half making low levels of progress in mathematics. By contrast, unaccompanied asylum-seeking young people make reasonable progress in learning English as an additional language. The PEPs of young people who underachieved at key stage 4 focus well on their needs and progress in Year 12.

50. Good progress has been made in developing the work of the virtual school, despite the fact that the post of virtual school head had, until recently, been vacant. The virtual school maintains accurate data on the attainment and progress of children, which it uses to prioritise work with those at risk of underachieving. The virtual school board is ambitious for children and young people, interrogates reports and data carefully and holds the virtual school to account. However, it is only in the last 12 months that the virtual school has started to support early years and post-16 learners. There is more to be done to consolidate its role and impact across the age range.

51. Nine children looked after are following reduced timetables for health or behavioural reasons. All have intensive support and are appropriately safeguarded, including three who are also at risk of sexual exploitation.

52. Action has been taken to reduce the number of authorised and unauthorised absences, which was slightly higher than for children looked after nationally. Settings now report changes in attendance to social workers and the virtual

school to enable prompt intervention. As a result, rates are improving. In the last three years, only one child looked after has been permanently excluded. This was unexpected and unavoidable. An alternative school was identified promptly, and the pupil is now making good progress.

53. While the availability of in-house foster placements has not kept pace with demand and the local authority relies heavily on independent fostering agencies to meet sufficiency, brothers and sisters are generally placed together. External placement providers say that the authority is very responsive to the needs of its children and young people. Where additional support is required, this is made available. Of the 358 children and young people who were being looked after at the time of this inspection, 203 (57%) are placed outside the local authority boundary, 109 of these in neighbouring authorities. Children living out of area have timely health assessments, prompt access to primary health services and suitable education. (Recommendation 9)

54. The local authority responds promptly to enquiries from those interested in fostering. Progress from the initial stage to full assessment is timely. The service focuses appropriately on prospective carers' motivation and their ability to safeguard children and young people. Applicants are prepared well and, once approved, receive good support, supervision and training.

55. In most cases, permanence is considered at the second looked after review. However, apart from those for whom adoption is considered to be in their best interests, permanence in all its different forms is not consistently well addressed or followed through into the care planning process. Until very recently, the local authority has not been making effective use of special guardianship orders to achieve permanence for children with relatives, friends or foster carers. The local authority has also been slow to review those children who are the subject of care orders and have been living with their birth families, in some cases for considerable periods of time. This is changing. The local authority now has clear plans in place to address both sets of issues, although it is too early to evaluate the impact of the action that is being taken. (Recommendation 8)

56. As part of its drive to adopt a much more robust approach to permanence, the local authority is also reviewing the relatively high number (92) of children and young people, excluding unaccompanied asylum-seeking children, who are accommodated under section 20 and also the circumstances of all children looked after who are not living in long-term placements. In the last 12 months, permanence through long-term fostering has been achieved for 18 children. A further nine children are progressing towards a match with permanent long-term foster carers. However, there is still a long way to go.

57. The quality of care plans seen is variable. There are as many examples of care plans that need to be significantly strengthened as there are of good

care plans. Good examples focus on outcomes, and are specific and measurable. Weaker examples include plans that are not specific to individual children, lack focus, do not set out clearly who needs to do what by when and, in some cases, do not effectively address issues of children's diversity. Inspectors also saw a small number of cases in which rehabilitation plans had either not been fully developed, or been allowed to drift, or were no longer relevant or realistic. This is unhelpful for children, and confusing for them and their carers. (Recommendation 3)

58. Children's plans are regularly reviewed by independent reviewing officers (IROs), and 90% of reviews are completed on time. Children are encouraged and well supported to contribute to and take part in their reviews, and 90% of children looked after between 13 and 16 years old do so. However, the local authority recognises that, when IROs make use of the escalation process to raise issues or concerns on behalf of children, the response of social workers and their managers is not consistently rigorous. In some cases, this results in drift and delay. Action is being taken to increase the effectiveness of management oversight in this area.

59. While the Children in Care Council (CiCC) was previously involved in, and made a significant contribution to the redesign and recommissioning of the emotional well-being and mental health service, Solar, it has effectively been at a standstill since the restructuring last year of children's social care services. The council has not met for some time. Core members of the CiCC who are keen for it to be an active and effective forum representing the views of children looked after have been left feeling disappointed and disillusioned. They also regret the fact that there have not been any events to celebrate and value the progress and achievements of children looked after for some time. (Recommendation 11)

The graded judgement for adoption performance is that it is good

60. Adoption performance is good. Adoption is routinely considered for all children in need of permanence. Drive and determination, with an appropriate and demonstrable sense of urgency, mean that the local authority is increasingly effective in securing permanence for children through adoption, when this is in their best interests. The adoption team manager's involvement in the early stages of care planning, when permanence options for children are discussed and explored, facilitates this approach. Children experience very few moves before placement because, when adoption is in their best interests, it is fully integrated into the planning process.

61. Children and adoptive families benefit from a service that is well led and managed. The progress of children who are the subject of legal proceedings

or who already have placement orders is monitored more rigorously than those who have been assessed as needing a different form of permanence. Regular and effective monitoring meetings make good use of an adoption tracking tool to check and rate progress using a red, amber and green(RAG) scale. This level of scrutiny means that managers are able to identify any slippage promptly and take appropriate action to avoid delay.

62. Members of the adoption team are reflective, creative, show tenacity and act as passionate advocates for children. On occasion, for example, when The Children and Family Court Advisory and Support Service and the courts have seriously questioned whether adoption is appropriate or realistic for children with complex needs, the local authority has not given up. Its persistence and dogged determination to find the right families eventually resulted in placement orders being granted.

63. Family-finding strategies are well developed. Early consideration is given to approved in-house adopters. There are also good systems in place to track adopters who have been approved through the local adoption consortium. Where appropriate, prompt referrals are made to the adoption register and other extended family-finding services. The local authority is confident that plans to establish a regional adoption agency, Adoption Central England, will further strengthen family finding and increase placement choice.

64. The adoption reform grant has been used to good effect to increase the capacity of the adoption service, for example by funding a family-finding worker post. Effective family finding ensures that the right matches are identified for children and young people with adopters who can offer them safe and nurturing lifelong care. Although placing groups of brothers and sisters together is challenging, the service has made good use of the well-developed local consortium to do so. This has resulted in five groups of brothers and sisters being placed together in the last 12 months.

65. While the number of children adopted in 2015–16 was down slightly on the year before, 12 as opposed to 15, currently 24 children have active plans for adoption, including two who have disabilities and complex needs, three from minority ethnic and faith backgrounds, and five aged five or over. This provides further evidence of the local authority's commitment to achieving permanence through adoption when it is in a child's best interests, even if the associated challenges mean that it may take longer to achieve.

66. Timeliness has been an issue. However, the local authority has a detailed and comprehensive understanding of the factors at play, including those exceptional cases that involve long legal proceedings and take a disproportionate length of time from children entering care and being adopted by their foster carers, albeit with the benefit of placement stability in the interim. In other cases, delays have been caused by the length of time taken to find a suitable match for children with complex needs. However, contemporary practice evidences definite signs of improvement. The local

authority's own data for 2013–16 figures shows this in terms of the average length of time taken between children entering care and moving in with their adoptive families

67. Practice is sharply focused on finding the right adoptive families for children. Whenever possible, children are matched and placed with minimum delay. Inspectors saw two examples of two children who had been matched and placed within three months of the placement orders being made. Performance in 2012–15, against the adoption scorecard indicator of children who wait less than 18 months between entering care and moving in with their adoptive families, was 50%. This is in line with the national average of 51%.

68. Recognising the need to increase placement choice in response to the diverse needs of children, including brother and sister groups, children who have disabilities and complex needs, older children and children from minority ethnic backgrounds, the local authority has revised and refreshed its adoption recruitment strategy. This has led to an increase in the number of adoption enquiries. In 2015–16, 19 adoption applications were completed at stage two, resulting in nine adoptive placements. Five more approved adopters are being matched with children. With a clear policy framework around 'foster to adopt', there is already one such arrangement in place and another three in the pipeline.

69. Adopters' assessment reports are strong. They are detailed, thorough, child centred and full of information about applicants' histories. They carefully consider how individuals or couples can provide children and young people with lifelong stability and security. Robust analysis identifies potential adopters' strengths and any areas of support that they might need, as well as addressing issues around difference and diversity. Rigorous scrutiny of prospective adopters by the adoption and permanency panel ensures that children's needs, not least for physical safety and emotional security, are carefully considered. The panel's recommendations are systematically reviewed by the agency decision maker, whose decisions are well balanced and timely. All of the adopters consulted by inspectors described the recruitment process as timely, effective, smooth and supportive. They said they felt that they had been well prepared for the task of becoming adoptive parents, particularly by the training provided.

70. Child permanence and adoption support reports are comprehensive, analytical and of a consistently high quality. They reflect a good understanding of children's needs and histories. Information about birth parents is thoughtfully considered. These reports are sensitive to the impact on both the birth parents and other family members, including the extended family.

71. Life-story work is well supported by an experienced life-story consultant, who also offers advice and support to adopters. Inspectors saw some excellent

examples of life-story work, and of life-story books that described the child's journey wonderfully well and captured their past and current experiences in a clear, sensitive and child-friendly manner. Adopters speak very highly about the timeliness and positive impact of life-story work, and are generous in their praise of the quality of their children's life-story books.

72. No adoption placements have broken down within the last three years. This is due in no small part to the careful consideration given to the approval of adopters, the quality of the matching process and the success of the ongoing post-adoption support available to families.

73. The local authority provides good pre-and post-adoption support, including therapeutic support. Currently, 29 families and 41 children are being supported post-adoption, including 12 families who are in receipt of post-adoption allowances and four adults who are being supported to access their adoption records. One adopter, who had been able to access the adoption support fund to pay for direct work with her child, said 'I would be lost without this support.' Adopters' extended families are also able to access support, for example by participating in training and/or having books on adoption made available to them. At the time of this inspection, there were 12 direct contact arrangements, with the local authority being involved directly in seven of them. In addition, where agreed as part of children's plans, 'letterbox' arrangements support adoptive families to exchange news with children's birth and extended families.

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

74. The local authority is in touch with 206 (97%) of its 212 care leavers. The majority of care leavers benefit from positive relationships with their social workers and personal advisors. Most benefit from effective wrap-around support and services to safeguard and protect them, and to promote their independence.

75. Unaccompanied asylum-seeking young people receive specialist advice and support from the child asylum and post-16 service. This enables the team to develop and maintain an effective overview of their needs and progress. Three of the six care leavers with whom the local authority is not in contact were originally accommodated as unaccompanied asylum-seekers. They only stopped contact after they had been refused leave to remain.

76. Most young people live in suitable accommodation. The level of support provided is good. A specialist accommodation officer assists care leavers, including asylum-seeking young people, to apply for tenancies and secure their benefit entitlements. Care leavers who become parents are helped to

get appropriate tenancies and are supported by the family nurse partnership scheme to develop their parenting skills. Tenancy officers work with young people who are at risk of losing their tenancies.

77. The quality of support that care leavers receive in order to develop their independent living skills is good. Social workers and personal advisers take care to ensure that young people are helped to learn to manage their finances and develop the practical skills that they need for the future. Care leavers who met with inspectors spoke very positively about the support that they have received from their personal advisers or social workers, and about the quality of their relationships with them.

78. However, while good use is made of a range of resources, including two training flats, four supported lodgings placements and floating support to prepare care leavers for independence, for some care leavers the choice of accommodation options available is limited. Currently, the local authority is heavily reliant on hostel-type facilities for 16- to 24-year-olds. Some of these are provided and managed by private and voluntary organisations, both inside and outside the borough, including a number of high-rise blocks that have been redeveloped and refurbished as part of the regeneration programme in the north of Solihull. This situation is largely a reflection of the local property market and a product of the pressures on existing housing stock. Some care leavers told inspectors that they felt that the wide age range that these facilities cater for is not always suitable, particularly for younger care leavers.

79. Forty care leavers are living in semi-independent accommodation in houses in multiple occupation. While their needs are carefully assessed beforehand and floating support is provided, this is not ideal. The local authority recognises that it needs to increase the range of accommodation options available, including specialist accommodation and support for more vulnerable care leavers, including those who are at risk of child sexual exploitation or have mental health issues. (Recommendation 10)

80. Additionally, inspectors identified five care leavers, one of whom was under the age of 18, who had been assessed for several years as being at risk of sexual exploitation. Although all are being supported, the focus of attention in multi-agency meetings has been on information sharing and work with the young people to manage and reduce the risks to which they are exposed. Insufficient action has been taken by the council and its partners to disrupt the activity of the alleged perpetrators, and significant risks remain.

81. All care leavers have good up-to-date pathway plans that are regularly reviewed, either by service managers or, in the case of care leavers who are under 18, by independent reviewing officers. This level of scrutiny ensures that plans are relevant and appropriate, and are updated when necessary. Social workers and personal advisors use checklists effectively to make sure that young people's needs, wishes, feelings and aspirations are explored and

recorded. Most pathway plans are clear and comprehensive, and list options and alternatives in recognition of the fact that the young person's circumstances may change. However, the extent of young people's contribution is not always clear. The local authority also recognises that the views of foster carers are not always well recorded.

82. Good attention is paid to care leavers' health. In the majority of cases, health issues are clearly identified, effectively addressed and well met. Care leavers who live in Solihull have prompt access to counselling and emotional well-being and mental health services. A strong focus on supporting care leavers with additional healthcare needs is helping them to manage their health conditions better. However, in a minority of cases, when care leavers are involved in substance misuse and/or experiencing emotional well-being or mental health problems, or are not engaging with the support and services offered, a lack of tenacity on the part of the professionals involved has resulted in poorer outcomes. Similarly, care leavers who are living out of borough do not always have the same easy access to emotional well-being and mental health services as their counterparts in Solihull.

83. When young people leave care and formal support from the designated looked after health service comes to an end, care leavers receive comprehensive health passports, together with a personalised letter with the contact details for the designated nurse. As a result of the positive relationships that she has developed with them, it is not uncommon for care leavers to contact the designated nurse at a later date. The designated nurse is always happy to provide advice or information, or to signpost them to the appropriate service.

84. Young people who wish to remain with their foster carers after they turn 18 are encouraged to do so. At the time of this inspection, 15 young people were living with their former foster carers under the terms of a 'staying put' arrangement.

85. From an early stage, young people are actively encouraged to consider their post-16 options. Two careers advisers, who are part of the virtual school team, work well with schools, social workers and personal advisers to provide timely and effective advice and guidance to young people. Links between the leaving care team, the virtual school and local providers of education and training are well developed. The number of young people participating in education, training or employment (EET) has increased steadily over the last three years. In March 2015, 93% of 16-year-olds, 88% of 17-year-olds and 78% of 18-year-olds were in EET. This provides a firm foundation for young people as they leave care. The authority tracks the EET activities of 19- to 21-year-olds well. Only 3% are unknown.

86. However, in the case of young people who are not in education, training or employment and/or do not show a significant level of commitment to learning, pathway plans are not sufficiently specific about what professionals

will do, or by when, to help them to explore their options. This has the potential to limit the effectiveness and impact of the pathway plans.

87. The council is increasingly proactive in establishing agreements with contractors involved in major infrastructure developments to employ young people and prioritise opportunities for care leavers. Currently, four care leavers have apprenticeships. Twenty-nine care leavers are at university, with a further five due to enrol in September. The local authority has been particularly successful in working with care leavers who originally arrived in Solihull as unaccompanied asylum-seeking children or young people, 18 of whom are now at university.

88. The number of care leavers in custody is relatively low, at five. Pathway plans are in place, young people are visited regularly and personal advisors work well with the youth offending team, probation service and housing providers to accommodate young people on release and encourage them to undertake meaningful activities. One young person who was recently released is now in full-time employment.

89. In recent times, care leavers have not had an opportunity to come together to celebrate their own and each other's achievements. Young people who spoke to inspectors said that this was something that they missed. The manager of the leaving care team is aware of the issue and has identified a personal adviser to work with care leavers to address this omission.

90. Although there is a clear housing protocol in place in relation to the accommodation needs of homeless young people, a shortage of emergency accommodation means that, in the last 12 months, a very small number of care leavers have been placed temporarily in bed and breakfast accommodation. This was for between two-and-a-half and five weeks before suitable accommodation was found for them. In each case, the use of this accommodation was a means of providing urgent protection to children at risk of sexual exploitation and was comprehensively risk assessed. Nevertheless, this is still not good enough. (Recommendation 10)

91. Care leavers receive good-quality information about their rights and entitlements in the form of a clear and accessible booklet. Personal advisers provide timely advice on financial matters and work with young people to help them to understand their entitlements. Although some care leavers who spoke to inspectors were not aware of the council's 'We listen, we care' promise, they were all clear, and spoke knowledgeably, about their entitlements. However, not all care leavers have received a copy of their birth certificates.

Leadership, management and governance	Requires improvement

Summary

Senior managers and leaders have a clear sense of vision and purpose. The pace of change has increased. Improvements are being made. However, children and young people are not yet being consistently well served. Practice standards are improving but, in some areas of the service, not quickly enough. Frontline managers, many of whom are relatively new in post, do not always pay rigorous attention to detail or provide the right level of critical challenge. This contributes to drift and delay for some children.

While there is a strong focus on performance, senior managers do not have a direct line of sight on some key aspects of frontline practice. Audits, which focus primarily on process and compliance, tend to under- or over-estimate the impact of current practice on the experience and progress of children and young people.

A high turnover of staff, and an organisational structure that involves a significant number of built-in transfer points, have led to repeated changes of social workers in some cases. While staff turnover is now much reduced, the lack of continuity has made it difficult for some children and young people to develop meaningful relationships with their social workers and has contributed to 'start again social work' practice.

With clear lines of reporting and accountability, governance arrangements are robust. Highly developed strategic partnerships are being used effectively to support transformational change.

The health and well-being board is influential in driving the improvement agenda. Well-developed joint commissioning arrangements are responsive to the needs of local communities. However, fostering recruitment strategies are not well targeted. They are general, rather than specific. The local authority does not have enough foster carers with the right mix of skills, knowledge and experience to meet current and future demand.

The Children in Care Council (CiCC), which previously made a significant contribution to the design and development of the emotional well-being and mental health service, is currently in limbo. This is particularly surprising, given that the corporate parenting board is well organised, well led, in touch with the wishes and feelings of children in care and is making a difference.

The local authority has worked hard to ensure that, with average caseloads of 18, social workers have a working environment which is conducive to good practice. Manageable caseloads, good access to training and an active and effective principal social worker are increasingly making it easier to recruit and retain staff.

Inspection findings

92. Senior managers and leaders have a clear sense of vision and purpose. They are child focused, ambitious and driven. They are systematically putting in place the essential foundations for the local authority to achieve the consistency and quality of services that it aspires to. Children's social care services have been restructured in order to provide a sharper focus on key stages in the child's journey and make better use of resources. Having set up the multi-agency safeguarding services (MASH), which is making a real difference to the way in which contacts and referrals are dealt with, the local authority is now implementing its new early help strategy. This has been designed and developed in close collaboration with a range of different partners. Plans to create a 0 to 25 service for children who have disabilities are well advanced.

93. Good engagement with elected members and clear lines of reporting and accountability mean that governance arrangements are well developed and effective. Regular face-to-face contact between the leader of the council, the lead member for children's services, the chief executive and the director of children's services (DCS) ensures that senior managers and leaders have a shared understanding of the day-to-day challenges facing children's social care services.

94. However, the scrutiny function in relation to children's social care is underdeveloped. The scrutiny board was involved in designing and implementing a new fee structure for foster carers, and in the past 12 months has reviewed the development of the MASH and considered the implementation plans for the new early help offer. However, it is not yet offering the robust and systematic critical challenge that middle and senior managers need, and that children and families have a right to expect.

95. Highly developed strategic partnerships are being used effectively to support transformational change. The ongoing regeneration of the north of the borough, and the significant investment that has been made in schools there, are helping to improve the lives of children, young people and families. Perhaps because of these improvements, there is a powerful sense of organisations and people working together to get things done. The police superintendent, who is a member of the local authority's corporate management team, and his chief inspector, who chairs the Local Safeguarding Children Board sub-group against child sexual exploitation, have made significant contributions to the work to counter child sexual exploitation and domestic violence. This work is helping to safeguard children and families. Schools and academies are equally well engaged with, and are making a significant contribution to, safeguarding in general. They are also involved in specific initiatives, such as 'Prevent' and the threat of radicalisation. This means that issues and concerns are being identified and discussed and, where appropriate, referred appropriately to the Channel panel.

96. The health and well-being board is chaired by the lead member for children's services. The children's trust was absorbed into the board and this has strengthened it. It has a strong focus on ensuring that children and young people get the 'best start in life' and is influential in driving the improvement. It played a key role in the redesign and recommissioning of the new emotional well-being and mental health service, Solar, which went live in April 2015 and is being delivered by through a small consortium of statutory and voluntary organisations. By making better use of resources, Solar has reduced waiting times and made access to services possible for children and young people who previously would not have been able to do so. Schools are major beneficiaries, and are able to refer children who they are concerned about quickly and easily. Currently, 83% of children are seen within six weeks.

97. Well-developed joint commissioning arrangements are responsive to the needs of the local communities. They are informed by a clear and coherent joint strategic needs assessment and supported by a longstanding section 75 agreement with health services. Commissioners with relevant specialist knowledge and experience have led the way in re-providing substance misuse and domestic violence services, as well as the emotional well-being and mental health service. Public health, which transferred from the NHS to the borough council in April 2013, has been at the heart of that process. Contract monitoring arrangements are effective. Providers, both voluntary and statutory, speak very positively about the way in which they are encouraged and supported to be creative and innovative, as well as being challenged on key deliverables. As evidence of impact, the reconfigured substance misuse services have extended their reach to the point that Solihull now has a higher than national average proportion of parents and/or adults who are living with children in treatment programmes.

98. Sufficiency, not least in terms of in-house foster carers, remains a challenge. The foster carer recruitment strategy is general, rather than specific. It focuses on numbers and net gains rather than targeting specific audiences in order to recruit carers for particular groups of children, including older or Muslim children. Even so, the local authority is not meeting its own targets. The number of foster carers recruited in 2015–16 was low. Only seven new households offered 12 placements, three short of the local authority's target of 15. This is before taking into account the 21 foster carers who decided to stop fostering in 2015–16. If the local authority is not able to recruit more in-house foster carers, it will continue to rely on independent fostering agencies, which means that more children, not fewer, will end up being looked after out of borough. (Recommendation 9)

99. Senior leaders take their corporate parenting responsibilities seriously. The corporate parenting board is chaired by the lead member, who makes sure that members of the board have direct face-to-face contact with children and young people at regular intervals, away from the formality of the council chamber. With its own action plan and performance scorecard, the board is

making a difference. It was responsible for setting up a governing body for the virtual school, improving the timeliness of initial and annual health assessments, and introducing a more robust approach to monitoring the offer and completion of return home interviews. It also arranged for foster carers to be given delegated responsibility to approve sleepovers for children, without having to get permission from the child's social worker. Every child looked after receives an annual award and a personalised letter, hand-signed by the leader of the council and the DCS. However, in the last 12 months, there have not been any events to celebrate the progress and achievements of children looked after or care leavers.

100. The CiCC was involved in the design and development of the emotional well-being and mental health service, even choosing its name. Lately, however, it has been allowed to stagnate. It has not met for some time, leaving a committed group of core members feeling disappointed and disillusioned. (Recommendation 11)

101. The leader of the council and the chief executive meet with the chair of the LSCB at regular intervals, as do the DCS and the lead member. They welcome the LSCB chair's insights and challenges, not least because she is able to offer a different perspective, but equally they are able to, and do, challenge the chair of the LSCB and hold her to account.

102. While there is a strong focus on performance, the development of a robust performance culture is still a work in progress. Middle and senior managers regularly scrutinise performance data but, in its current form, it does not give them a direct insight into some key aspects of frontline practice, including, for example, the frequency and regularity of supervision. Additionally, some of the data in the children's information and performance system is unclear or unreliable. (Recommendation 1)

103. Quality assurance systems have been strengthened. The local authority has increased its use of audits to get under the surface of different types of activity to explore not just the quality, but also its impact and effectiveness. However, the current audit tool, and the way in which it is being used, tends to focus primarily on process and compliance. This has the potential to under- or overestimate the impact of current practice on the experience and progress of children in need of help and protection and children looked after.

104. The quality of management control at the frontline is variable. This is significant and has the potential to dent the local authority's ambition to provide excellent services for all children and families. As a result of the restructuring last year of children's social care services, there are a significant number of team and assistant team managers who are in a management or supervisory posts for the first time. The local authority has invested heavily in their development as leaders. However, in the short term, a lack of consistently robust critical challenge and rigorous attention to detail in some areas of the service have contributed to drift and delay, for some

children. This means that children and families are being let down every time that a weak assessment or plan is allowed to pass unchallenged, or an opportunity to explore and address permanence for a child is missed. What is required is a greater sense of urgency and a more ruthless focus on core practice in order to improve outcomes for all children. (Recommendation 2)

105. Over the course of the last 18 months, senior managers and leaders have consciously tried to inject a greater sense of realism, based on openness and transparency. Not afraid to be self-critical and always eager to learn, senior managers are demonstrably committed to continuous improvement. They are currently introducing a recognised model of practice, and plans to adopt the graded care profile are well underway.

106. Strong on complaints, the local authority acts on the learning from each one, using a spreadsheet to track the response and identify emerging themes. Additionally, 297 children and young people looked after have made use of the online portal, Viewpoint, since it was introduced in 2014. Responses are analysed and used to inform individual and corporate improvements. The local authority is also about to introduce a new system for gathering feedback from children and families who have been involved in child protection processes.

107. With productive working relationships between the Children and Family Court Advisory and Support Service, the family courts, the local family justice board and the local authority, the timeliness in completing care proceedings has improved significantly.

108. The recruitment and retention of social workers have been a major issue. During and immediately after the restructure of children's social care services, this resulted in increased staff turnover. This had a major debilitating effect. When combined with a lack of robust management oversight, it engendered a sort of 'starts again social work' practice, in some cases. It has certainly affected some children and young people's ability to develop and maintain meaningful relationships with their social workers. Action taken by the local authority has resulted in a significant improvement, and turnover is now down to 12%. This is an indication not only that things are beginning to settle down, but that the restructure has had a positive impact on recruitment and retention.

109. Acting as an effective bridge between senior managers and frontline social workers, the principal social worker has been instrumental in translating into practice the messages for improvement gleaned from audit activity. Improvements in the quality and use of chronologies are due in no small part to the work done by the principal social worker. Close relationships with local universities are supporting continuing professional development. Monthly newsletters are used to promote training and its take up.

110. The local authority provides good training and development opportunities. The average caseload is 18 for social workers and 12 for newly qualified social workers (NQSWs). Agency staff are used to backfill for NQSWs in order to ensure that they have protected caseloads. This is further evidence of the local authority's commitment to creating an environment that is conducive to good social work practice.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is good

Executive summary

By providing strong leadership, effective coordination and robust challenge, the LSCB is helping to strengthen the work of partner agencies with children and families in Solihull. As well as improving the quality of the services provided, this is leading to better outcomes for children. Ably supported by a very capable business manager, the independent chair of the LSCB provides clear direction and guidance. With good engagement from board members, there is a real sense of commitment and momentum. The work of the LSCB is increasingly focused, coherent and authoritative.

The LSCB makes good and effective use of performance management information and multi-agency audits to 'home in' on its three strategic priorities: children who go missing or are at risk of child sexual exploitation; early help; and neglect. Once areas for improvement are identified, the board provides effective challenge. The board is doubling the size of its case audit sample in 2016–17 to strengthen its overview of the quality and impact of practice and compliance with practice standards, including the use of child sexual exploitation risk assessment tools. The board's improvement plan also includes a clear commitment to strengthen its focus on domestic abuse, and to work with children and young people living in homes affected by domestic abuse.

The board provides effective leadership around work with children and young people at risk of sexual exploitation and those who go missing. It ensures that collective efforts are well supported by a clear governance structure and an appropriate set of up-to-date policies and procedures.

Early help services are being monitored, but the board's challenge to partner agencies does not yet have the same rigour and focus evident in other areas of its work.

Training provided by the board is well-targeted, incorporates learning from local and national serious case reviews (SCRs) and is evaluated. To date, SCR work has been well managed by the independent chair but, looking ahead, she is unlikely to have the capacity to combine this with her primary role as chair of the board.

The child death overview panel (CDOP) is effective, not least in identifying relevant public health and practice improvement priorities. However, the CDOP needs to continue to work with health agencies to ensure that, when children die unexpectedly, a fully staffed rapid response service is available.

Recommendations

111. Strengthen the focus and rigour with which the new early help service is monitored, to enhance the effectiveness of the leadership and challenge provided by the board to partner agencies.

112. Ensure that the board has sufficient capacity to manage SCRs and any related learning reviews or single-agency case audits.

113. Ensure that, when a child dies unexpectedly, there are adequate rapid response arrangements in place.

Inspection findings – the Local Safeguarding Children Board

114. The engagement and commitment of partner agencies to the board is impressive. This is given direction and momentum by strong and effective leadership by the independent chair, supported by a highly capable business manager. The work of the board is supported by a clear and functional structure and effective governance arrangements. Taken together, this means that the LSCB is successfully fulfilling its role as 'critical friend' to partner agencies, providing leadership and challenge in relation to the quality and impact of services for children and young people in Solihull.

115. The LSCB has a small number of sub-groups that are focused on discharging the board's statutory responsibilities and delivering on its three key priorities: children who go missing or are at risk of child sexual exploitation; early help; and neglect. The work of these sub-groups is overseen effectively by an executive group that carefully considers performance data and audit findings, and sets the agenda for board meetings. Board meetings are sharply focused on the most important issues, with a strong emphasis on making a difference. For example, through its monitoring of practice, the sub-group to counter child sexual exploitation identified a number of concerns about the support provided to young people at risk of sexual exploitation once they had turned 18. Having discussed the issue, the executive group took it to the next full board meeting. As a result of this, and robust challenge by the independent chair, the local authority took appropriate action to ensure that young people continue to receive support after turning 18.

116. The LSCB works well with the local family justice board and the health and well-being board. Using the learning from an SCR, the LSCB has provided effective challenge and guidance to the health and well-being board, both on the development of the new education, health and care plans for children who have special educational needs or disabilities, and on the importance of ensuring that safeguarding issues and concerns are appropriately addressed.

117. The board regularly reviews a range of performance data, with particular attention to its three strategic priorities. It has a specific performance scorecard for each. The neglect scorecard is particularly strong, reflecting the

LSCB's commitment to implementing its strategy to counter neglect. As well as performance data, the scorecard also covers attendance at LSCB training on neglect and evaluation of the impact of this training.

118. The board has been involved in discussions about the development of the new early help strategy and receives regular updates on the implementation of the new early help offer that started in October 2015. However, the board's scrutiny of early help services does not show the same degree of rigour. While the board collects a range of relevant data, it has not yet focused on the key issues of whether there has been an increase in the number of early help assessments completed or sought to evaluate their impact. In that sense, the board has not provided the same degree of challenge, not least about the pace of change, as it has in other areas of practice. (Recommendation)

119. The LSCB's multi-agency audit programme in 2015–16 was well managed and focused appropriately on the board's priorities. It identified both good practice and areas for improvement, which were then used to inform the work of the board and to help to shape its priorities for 2016–17. For example, when audits identified a lack of understanding of the thresholds for intervention, the LSCB adapted its existing training courses to include a section on thresholds and decision making. However, although rigorous in their execution, the board's multi-agency audits in 2015–16 were completed using a relatively small case sample of 11. This means that the learning about particular areas of practice, which only featured in some of the children's cases, tended to be case specific rather than representative. For example, the LSCB's strategic priority on neglect includes a particular focus on the impact of the 'toxic trio' of domestic abuse, parental mental ill health and parental drug, alcohol and substance misuse. A larger audit case sample is required to be able to assess thoroughly the quality of practice in relation to these areas of concern. The LSCB is aware of this deficit and has agreed a case sample size of 24 for 2016–17.

120. A section 11 audit of how well partner agencies discharge their responsibilities to safeguard and protect children, which was carried out in the autumn of 2015, was very thorough. It was used effectively, not only to test compliance but also to identify thematic areas for improvement. This is also true of a more recent section 175 audit of schools. An LSCB education sub-group includes representatives from all of the 'collaborative' school groupings in Solihull, as well as from special and independent schools. This means that the level of schools' engagement is strong, both with the audit and with the LSCB.

121. Given the relatively high number of unaccompanied asylum-seeking children in Solihull, the LSCB has also taken the positive step of requiring the UK Border Agency to complete a self-assessment of how well it discharges its responsibilities to children and young people under Section 55 of the Borders, Citizenship and Immigration Act 2009.

122. The LSCB publishes and regularly updates its guidance on the threshold criteria for access to children's social care services. The document covers all the areas required by statutory guidance and is responsive to the latest developments in practice, such as a stronger focus on early help. Concerned that thresholds were not consistently well understood or applied by agencies, the board produced a short summary leaflet that was widely circulated. However, an independent review of the thresholds, which was commissioned by the LSCB and completed in February 2016, has highlighted the fact that the threshold between early help and children in need requires further clarification. As a result, the document is currently being revised, and this work has not yet been completed.

123. The LSCB's learning and improvement framework is clear, succinct and covers all matters expected by statutory guidance. It has a good focus on local priorities, and identifies how learning is disseminated and evidence gathered in order to show that it is making difference. The LSCB's training strategy and training programme are based on a review carried out in April 2015. The review brought together learning from Solihull's most recent SCR and national SCRs, existing local priorities, and feedback from children and young people in receipt of services. This has resulted in a well-targeted and well-attended programme of training. The board uses an effective online survey tool to gather feedback from course participants and their managers about the impact of training on their practice at three months after they have completed training. Almost all social workers spoken to by inspectors were positive about the quality of LSCB training. They were able to talk confidently about SCR learning and its relevance to their practice.

124. At present, the LSCB does not have a formal SCR sub-group to coordinate its work around SCRs, learning reviews and any single-agency audits that have been commissioned by the board. To date, this work has been led by the independent chair. In the event that further reviews or audits are required, over and above the work that is already underway, it is unlikely that the independent chair would have sufficient capacity to manage this on top of the demands of chairing the board. (Recommendation)

125. The child death overview panel (CDOP) has been effective in analysing information at the individual child and the thematic public health levels. For example, the CDOP has ensured that midwives and health visitors routinely use an assessment tool to identify the likely risk of sudden infant death, and that the protocol on the sudden and unexpected death of an infant is understood and implemented by all of the relevant agencies. However, despite ongoing efforts, including escalation via the board, the CDOP has not yet been able to ensure that health partners provide full 24/7 cover as part of the rapid response arrangements. (Recommendation)

126. Under the strategic leadership and direction of the LSCB, there are clear and appropriate structures in place to identity and respond to the needs of children at risk of child sexual exploitation and those who go missing from

home or care. Information about children missing education is well integrated into this process. The child exploitation sub-group advocates strongly on behalf of this vulnerable group of children, has a good oversight and is demonstrably committed to continuous improvement. However, it makes sense to extend the scope of multi-agency audits to ensure a fuller understanding of the quality and impact of practice, and to comply with practice standards. The LSCB monitors data on the prevalence and severity of assessed risks associated with sexual exploitation, on children and young people missing from home or care, and on the completion of return home interviews and the intelligence that they generate. The LSCB provides training, promotes awareness raising and challenges agencies to do better, as and when necessary. For example, at the time of this inspection, the LSCB was challenging the police and the local authority to improve the way in which they collate and analyse information from return home and police 'safe and well' interviews, better to inform their prevention and disruption activities.

127. The LSCB's annual report for 2014–15 is a clear and well-focused document that covers all of the relevant areas. The results of the board's monitoring and scrutiny of practice were used effectively to identify priorities for 2015–16 and to shape the board's business plan. Good progress has been made. Any outstanding actions have been carried forward into the 2016–17 improvement plan, which the board is now working on. The improvement plan encompasses the learning and recommendations from SCRs and areas for development identified through performance and practice monitoring. It sets out clearly the outcomes required, actions that need to be taken and the measures that will be used to monitor and maintain improvement.

Information about this inspection

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

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

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

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

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

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

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