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# Bristol City Council

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

and

**Review of the effectiveness of the Local Safeguarding Children Board[1]**

**Inspection date: 30 September – 22 October 2014**

**Report published: 5 December 2014**

| **The overall judgement is that children's services require improvement** |
|---|
| The authority is not yet delivering good protection and help and care for children, young people and families.<br>It is Ofsted's expectation that, as a minimum, all children and young people receive good help, care and protection. |

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

[1] Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and 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.

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# The local authority

## Summary of findings

### Children's services in Bristol require improvement because:

*Outcomes for care leavers are poor*

- Fifty per cent of care leavers are not in education, employment or training.
- The local authority is not in touch with 25% of its care leavers so cannot be sure that these young people are safe.
- Pathway plans are poor and do not set out clear actions to achieve good outcomes for care leavers.

*Educational outcomes for looked after children require improvement*

- Too many looked after children do not achieve well in school. Persistent absence is high and the quality of personal education plans requires improvement.

*The quality of social work practice is not consistently good*

- Insufficient priority is given to children in need. Some of these children do not have a plan, and a significant number who do have a plan, do not have their plan reviewed.
- The quality of assessments, plans and case recording is not yet of a good enough standard. Recording does not always reflect the good direct work undertaken by social workers with children and families.
- Social work visits to some children subject to a protection plan do not take place often enough.

*Leadership, management and governance require improvement*

- The corporate parenting plan is not up to date and provides limited focus and drive to improve services for looked after children and care leavers.
- There is no overarching strategic plan to tackle child sexual exploitation (CSE). Although a wide range of help and support is available, services are not well coordinated and practice is inconsistent. Missing children do not all receive appropriate 'return interviews'.
- High caseloads limit workers' ability to build meaningful relationships with children and young people, fully assess their needs and plan effectively.
- There are insufficient skilled foster carers to provide choice and meet the demand for places for older children and family groups.
- Performance management information is not of a good enough quality.
- In cases where poor practice was evident, there was insufficient management oversight or Independent Reviewing Officer (IRO) challenge.
- Supervision files do not consistently contain evidence of reflective discussion.

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## What does the local authority need to improve?

### Priority and immediate action

*Outcomes for care leavers*

1. Ensure that each care leaver has a pathway plan that contains an up-to-date assessment of individual needs and a clear plan with specific and measurable objectives that are understood and agreed by the young person.

2. Take action to re-establish contact with care leavers who are not in touch with the service and take steps to ensure they are all safe. Ensure that each care leaver has the opportunity to maintain a meaningful relationship with a leaving care worker and, for those young people with whom the local authority had lost touch, the reasons are fully recorded, collated, analysed and reviewed.

*Educational outcomes for looked after children*

3. Ensure that the attainment gap between care leavers and all children locally closes at a quicker pace; hold schools to account for the achievement of these young people.

4. Ensure that all personal education plans are timely and completed to a high standard, including clear time lines and measurable success criteria.

5. Evaluate the impact of the pupil premium funding on the achievement of looked after children, and adjust where necessary to achieve optimum outcomes.

6. Improve the attendance of looked after children and reduce fixed term exclusions.

*The quality of social work practice*

7. Ensure that all children in need have a good quality assessment and a clear plan that is regularly reviewed.

8. Ensure that all missing children, whether from home or care, are offered a 'return interview' carried out by an appropriately independent person.

*Leadership, management and governance*

9. Publish and implement an updated corporate parenting plan to drive improvement in the quality and coordination of services to address the current poor outcomes for looked after children and care leavers.

**Areas for improvement**

*The quality of social work practice*

10. Improve the standard of social work assessments, plans and recording across the city and provide training, coaching and supervision to achieve consistency of practice.

11. Ensure that 'return interviews' are used to inform planning for individual children and the themes from interviews are used to inform strategic planning in conjunction with the police.

12. Ensure that social workers engage well with family members at core groups and other meetings to ensure that children's needs are understood and met.

*Leadership, management and governance*

13. Implement and publish a multi-agency strategy to coordinate and measure the impact of services to tackle CSE and to support children who go missing from home or care. Ensure that staff are aware of the revised 'missing from home or care' policy when it is published.

14. Develop a new strategic plan with partner agencies that reflects current priorities to replace the 2011–14 Children and Young People's Plan.

15. Improve the quality of performance management information. This should include all relevant priorities, including care leavers in education, training and employment, care leavers missing, children at risk of sexual exploitation and the number and quality of child in need plans and pathway plans.

16. Ensure that all social workers have manageable caseloads allowing them the time to build meaningful relationships with children and their families and accurately assess need.

17. Ensure that there is a sufficient number of skilled foster carers to provide choice and meet the demand for family homes for older children and family groups.

18. Reduce school absence rates across the city. Learn from what worked well to improve primary school attendance, and seek new ways to improve attendance for all children.

19. Ensure that the quality assurance function within the IRO service enables IROs to comply with the requirements of the IRO handbook to monitor the effectiveness of social work practice in meeting children's needs.

## The local authority's strengths

20. Early help services for children and families are well targeted and coordinated. Children's centres and schools play an active role in delivering services for children under ten.

21. The local authority's Troubled Families project has effectively engaged and 'turned around' families involved with the service.

22. When child protection concerns are identified children are quickly safeguarded. Strategy meetings lead to swift action. Initial child protection conferences are held promptly and child protection conferences are well attended by agencies. Advocacy for children is used well throughout the child protection process.

23. The recently introduced 'Signs of Safety' social work practice model is leading to better engagement with children and parents.

24. Lessons learned from serious case reviews are helping to shape social work practice.

25. Multi-agency work to meet the safeguarding needs of children from the diverse communities of Bristol is well developed. This includes targeted work to tackle female genital mutilation (FGM).

26. Effective use of the Public Law Outline has helped to improve the timeliness of care proceedings.

27. Looked after children are seen regularly by their social workers and report that they feel listened to and have good relationships with them. Care plans are regularly reviewed and permanency for children is considered early in the planning process.

28. The local authority is successful in ensuring timely adoption for children when this is in their best interests and children in Bristol are adopted quicker than the national average.

29. The Strategic Director for People and his senior team have provided strong leadership through the 'Children First' reshaping of services.

30. The local authority has a stable, committed and skilled workforce. A comprehensive package of training and support is offered for new social workers. Training in the 'Signs of Safety' tools and methodology is offered to social work staff and those in other agencies who deliver the early help offer.

## Progress since the last inspection

31. The last Ofsted inspection of Bristol's safeguarding arrangements and looked after children was in May 2010. The local authority was judged to be good for both services.

32. A number of areas for improvement from that inspection have not been adequately addressed. In particular this includes the need to improve the quality of assessments, children in need plans and case recording; insufficient placement choice for older children and for brothers and sisters to be together; and the need to review social worker capacity to meet service demands and ensure that social workers have manageable caseloads.

33. Outcomes for care leavers have deteriorated since the inspection in 2010, pathway plans are poor and too many are not in education, employment and training.

34. Bristol's adoption service was also inspected in 2010 and was judged as outstanding. The local authority has kept pace with the changes in adoption and is maintaining a good standard overall in this area, but the quality of child permanency reports is not consistently good.

35. Through the new senior management team, the local authority has a good understanding of the weaknesses, and work is underway to reorganise services under its 'Children First' programme.

36. Improvements have been achieved in the early help offer, the clarification of thresholds for access to services, senior management capacity in children's services and some additional social work posts. The local authority has introduced rolling three-year budgets to support planning, and has created a Children and Families Board, which is helping to shape strategic inter-agency service planning focused on children.

37. An effective joint protocol to respond to the needs of young people who present as homeless includes a range of provision to ensure that young people receive a prompt service. There are currently no young people aged under 18 known to children's social care who are living in bed and breakfast accommodation.

## Summary for children and young people

- Inspectors found that many services in Bristol need to improve, though some are helping children and young people well.
- Care leavers need more help to get jobs, attend further education or access training. The people who support care leavers are not in touch with enough of them and do not know if they are all safe. Some care leavers told us that they did not know about pathway plans. These are plans that care leavers should be closely involved with, that should help to make clear what action will be taken to help to prepare them for independence and adulthood.
- Too many looked after children do not get enough support to help them do well at school.
- Social workers need to make better plans with children and families and keep clearer records of the work they do. This would help them to know whether things are improving for children and their families.
- Some social workers have too much work to do which means that they do not always have the time to help children well enough.
- The local authority needs to develop clear plans to help improve services for looked after children and vulnerable young people, such as those at risk of sexual exploitation and those who go missing from home or care.
- Early help services, such as children's centres, family intervention teams and youth services, are helping children and families to manage their lives better.
- When there are concerns about the protection of children and young people, agencies such as the police, health and social care work together quickly to protect children.
- Social workers and others, such as health visitors, work well with children and parents and ask the right sort of questions to understand what early help services they need.
- Looked after children feel listened to, and in many cases, plans are made to help them to move quickly to a permanent home.

## Information about this local authority area[2]

### Children living in this area

- Approximately 90,500 children and young people under the age of 18 years live in Bristol. This is 21% of the total population in the area.
- Approximately 25% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 22% (the national average is 18%)
  - in secondary schools is 22% (the national average is 15%).
- Children and young people from minority ethnic groups account for 34% of all children living in the area, compared with 22% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Somali and Mixed White/Black Caribbean.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 20% (the national average is 18%)
  - in secondary schools is 15% (the national average is 15%).
- Bristol's population is increasing, particularly in the younger age groups. The number of children aged four and under rose by 36% between 2003 and 2013.

### Child protection in this area

- At 30 September 2014, 3,500 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 3,712 at 31 March 2013.
- At 30 September 2014, 466 children and young people were the subject of a child protection plan. This is an increase from 392 at 31 March 2013.
- At 30 September 2014, 13 children lived in a privately arranged fostering placement. This is a decrease from 17 as at 31 March 2013.
- Since the last inspection, 12 serious incident notifications have been submitted to Ofsted and five serious case reviews have been completed or were on going at the time of the inspection.

[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 looked after in this area

- At 30 September 2014, 696 children were being looked after by the local authority (a rate of 77 per 10,000 children). This is a reduction from 719 (82 per 10,000 children) at 31 March 2013. Of this number:
  - 251 (or 36%) live outside the local authority area
  - 30 live in residential children's homes, of whom ten live out of the authority area
  - 11 live in residential special schools[3], of whom five live out of the authority area
  - 587 live with foster families, of whom 223 (or 38%) live out of the authority area. The majority of those who live out of the area live in adjacent local authorities.
  - 11 live with parents, of whom one lives out of the authority area
  - 11 are unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been 46 adoptions
  - 44 children became subjects of special guardianship orders
  - 290 children ceased to be looked after, of whom 18 (6%) subsequently returned to be looked after
  - 25 children and young people ceased to be looked after and moved on to independent living
  - five young people ceased to be looked after and are now living in houses of multiple occupation.

### Other Ofsted inspections

- The local authority operates seven children's homes (including two providing short breaks). Five were judged to be good or outstanding in their most recent Ofsted inspection.
- In June 2013, Ofsted carried out a focused inspection of Bristol's schools as part of a programme of inspections in local authorities with a low proportion of good and outstanding schools. Fifteen schools were inspected. Ten of the schools improved their overall effectiveness grade from the previous inspection, one to outstanding and nine to good. One remained good while four were judged still not to be providing the quality of education expected. In the South West region, Bristol had the greatest increase in the proportion of good or outstanding primary schools in 2012/13.

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

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**Other information about this area**

- The City Director, who acts as the Chief Executive Officer, has been in post since May 2013.
- The Strategic Director for People has been in post since January 2014. The post includes the roles and responsibilities of the Director of Children's Services.
- The chair of the LSCB has been in post since September 2014.
- Vista, Bristol's Social Work Practice, has been operational since April 2012. The practice works with up to 140 looked after children for whom the plan is to remain in care.

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## Inspection judgements about the local authority

| Key judgement | Judgement grade |
|---|---|
| The experiences and progress of children who need help and protection | Requires improvement |

**Summary**

Early help services for children, young people and families are well targeted and coordinated so that they receive the help and support they need at the right time. Children's centres and schools play a strong part in delivering such services for younger children, and the youth service provides good, targeted interventions. The Troubled Families service has been successful in engaging and turning around those families with whom it works.

Thresholds for access to social care services are understood and applied by most partners, but the police do not risk assess the incident reports they send to the First Response Team.

Children in need services are insufficiently targeted and coordinated. Not all children who are assessed as in need of support have a plan in place and, for those who do their plans are not reviewed regularly enough.

Although there are examples of good practice with children going missing and an increased level of awareness of child sexual exploitation, more needs to be done to consolidate this area of work.

The quality of social work assessments, child protection plans and case recording is not consistently good enough.

Social workers with high caseloads do not have time to achieve the required standards consistently. There are many examples of social work interventions leading to improved outcomes for children, but more needs to be done to consolidate practice in order to improve consistency.

Due to service demand pressures, social workers and their managers do not always complete tasks or complete them to a good enough standard. This has reduced the quality of service experienced by a small minority of children and families.

The majority of social work and management decisions effectively protect, safeguard and promote the well-being of children.

38. Insufficient priority is given to children in need to ensure that their needs are consistently well assessed and reviewed. Some children in need do not have a plan and a significant number do not have their plan reviewed. Some children in need for whom there are concerns about sexual exploitation do not have assessments, or their assessments have not been updated in line with risk. Some of these plans have not been reviewed in a timely way.

39. Within the multi-agency arrangements for the delivery of CSE services, responses are insufficiently coordinated and practice is not consistent. Not all professionals are alert to the warning signs of CSE and social workers do not always use a specific screening tool for children and young people at risk. Despite this, there is improved identification of CSE and the number of known cases has increased from 53 (March 2014) to 70 (October 2014). Social workers work hard to establish and maintain relationships with young people who are known to be at risk of CSE and understand that persistence is needed in these cases. A wide range of voluntary sector, local authority and partnership services is available to victims of CSE, and these are having a positive impact in reducing risk to children and young people.

40. The number of children missing from home reduced from 60 in September 2013 to 40 in September 2014. The number of children missing from care also reduced, from 62 in September 2013 to 28 in September 2014. Information on missing children is collated but not effectively evaluated, so the reasons for these changes are not fully understood by the authority. The 'missing from home' policy is not up to date and there is insufficient integration of data, policies and procedures for children missing or at risk of CSE. Some social workers are unaware of the difference between police 'safe and well' interviews and 'return' interviews. Not all young people who are subject to a child in need or child protection plan and go missing, receive a return home interview by an independent person and, for those who do, this information is not consistently entered into case records.

41. The quality of social work assessments and case recording is not consistently good enough. Recent practice is much improved and there are many examples of good assessments and record keeping by social workers. However, other workers, particularly those with high caseloads, struggle to do all of their work on time and to the right standard. Assessments and case records do not always reflect the good direct work with children and families undertaken by social workers. Chronologies and statutory visits are not always sufficiently detailed to inform assessments and plans and the voice of the child is not sufficiently strong in assessments or recording.

42. Some child protection plans do not effectively measure progress or describe clearly what action must be taken, by when and by whom. The frequency of social work visits to see children stipulated in child protection plans is not always proportionate to the risk resulting in some children not being seen often enough. Core groups are held regularly, they are well attended and there are many examples of effective multi-agency work to safely reduce risk for children. However, some social workers lack the skills to chair these meetings effectively, so opportunities are missed to engage parents and carers effectively in the planning and review process.

43. The re-structuring of early help services has led to improved systems for supporting children and families. These involve three geographically based early help coordinators and multi-professional family intervention teams, alongside a commissioned open access youth service with a good range and quality of additional targeted provision. Work with families under the 'Troubled Families' initiative is also delivered by this range of services, all of which use Bristol's new Single Assessment Framework as a common spine for assessment and service delivery. These services help to make a positive impact on children's lives. There are many examples of children and families receiving the early help they need and this is ensuring that risks reduce. Some parents and asylum seekers who met with inspectors said the quality of the service they receive is 'amazing'.

44. Referrals to children's social care have been strengthened through establishing the First Response Team (FRT). This team provides a single point of access to both early help and statutory services. The threshold document launched in February 2014 is now well understood by partner agencies and is leading to a more consistent understanding. With the exception of the very high number of contacts received from the police, concerns are referred appropriately by partner agencies, which provide sufficient detail to support social workers to make decisions. Although the police are planning action to prioritise contacts, the FRT continues to struggle with the high volume of such work, which has led to delays for some children in receiving the help they need. The threshold for access to services for children at risk of harm, neglect or abuse is understood by social workers and managers and correctly applied in most cases. In a small number of referrals seen, workers in Duty and Assessment Teams were over-optimistic about the ability of early help services to address the presenting needs, and the decision not to progress through social work services was soon followed by a repeat referral.

45. When child protection concerns are identified, these cases are effectively prioritised so that children who need protection are safeguarded. Strategy meetings involve the relevant agencies and lead to swift action. Performance on the timeliness of initial child protection conferences has significantly improved from a low base and is now better than similar local authorities, with 80% completed within 15 days of the strategy meeting decision. The proportion of child protection review conferences completed within timescales has improved from a low base to 94%.

46. Child protection conferences are well attended by partner agencies, and the recently introduced 'Signs of Safety' social work practice model is beginning to improve engagement with children and parents. Social workers see children regularly so that they know and understand the needs of children and families well. Advocacy is used well throughout the child protection process to ensure that the views of children and parents are heard and understood.

47. An effective emergency duty service commissioned from a neighbouring local authority ensures continuity between the daytime children's social care and out-of-hours services. Some delays have occurred when strategy meetings are required out-of-hours, when Police Protection Unit officers are not available between 5.30pm and 8.00am; there are plans to tackle this issue.

48. An effective joint protocol to respond to the needs of young people who present as homeless includes a range of provision to ensure that young people receive a prompt service. There are currently no young people aged under 18 known to children's social care who are living in bed and breakfast accommodation.

49. Social work teams are staffed by committed and skilled workers who are passionate about their role, and know the local communities and their cases well. There are many examples of social work interventions leading to improved outcomes for children. Parents routinely receive copies of all meeting minutes, assessments and plans to support effective work. Most parents who met with inspectors expressed their satisfaction with the work of their social worker, even when they had to hear difficult messages.

50. Lessons learned from serious case reviews help to shape practice. For example, in cases seen by inspectors where 'disguised compliance' was an issue, this was effectively identified and acted upon as part of the assessment and planning process.

51. Services are targeted in the most deprived areas of the city, where there is a combination of poverty and child deprivation. Domestic abuse is the most commonly recorded risk factor in children in need and child protection cases. From April to June 2014, 777 open social work cases had domestic abuse as a significant risk factor. Work with families where there is domestic abuse, is closely aligned to other interventions in, for example, drug and alcohol misuse and mental ill health. Of the cases involving domestic abuse, 485 also involved substance misuse and 437 alcohol misuse, while in 510 cases, parents were identified as having some level of mental health need. Multi-agency risk assessment conferences (MARAC) ensure that high-risk domestic abuse cases are managed well and services effectively engage families. For example, during the year, 114 child victims of domestic abuse have received a direct service to support their emotional well-being from Next Link Domestic Abuse Services commissioned by the local authority and the Safer Bristol partnership.

52. Multi-agency work to meet the safeguarding needs of children from the diverse communities of Bristol is well developed. This includes targeted work to tackle female genital mutilation (FGM), including support for victims and unborn babies. Services for children with a disability are well planned and there are many examples of the needs of children with disabilities being met well, for example, through the use of advocates who have the skills to communicate with even the most severely disabled children so that their voices are heard. Good multi-agency support is provided to this vulnerable group of children.

53. There are 26 children missing education (CME) who are not registered as pupils at a school or receiving suitable alternative education; this number is reducing. However, an additional 75 pupils miss out on education through not receiving either full time or suitable education. The local authority has improved procedures to monitor and track the attendance of pupils, which has led to improved primary school attendance, but the overall attendance of children and young people remains too low. Increasing emphasis is now placed on the training and development of staff to support the development of pupils' awareness of keeping safe through the personal, social and health education (PSHE) curriculum. Further work is planned to highlight issues on radicalism and safeguarding children.

54. Effective arrangements are in place for managing and monitoring allegations against professionals. There is a clear process for managing child protection investigations by the local authority designated officer (LADO). Responsive arrangements are in place for the LADO to raise awareness of the role and provide training to a range of agencies, including work with the fostering team, faith groups and schools.

55. Although the number of privately fostered children is low (13), arrangements to promote awareness are comprehensive. Training and awareness raising have taken place in social work teams and schools. Sampling of cases in the FRT confirmed that social work practice is alert to the needs of privately fostered children, although the local authority acknowledges that visits to see these children are not always undertaken within the statutory timescale.

| Key judgement | Judgement grade |
| --- | --- |
| The experiences and progress of children looked after and achieving permanence | Requires improvement |

**Summary**

Care leavers are not supported well and pathway plans are poor. Too many care leavers are not in education, training or employment and some do not know what they are entitled to when they leave care and move into independence. Approximately 25% of care leavers do not receive a service from the local authority, and it is not known whether these young people are safe.

The educational achievement of looked after children requires improvement particularly at Key Stage 1 and Key Stage 4. Persistent absence is high and the quality of personal education plans is not good enough.

The quality of written assessments requires improvement. Too many care plans are not up to date and lack detailed information. Chronologies are not consistently used and children's wishes and feelings are not always recorded. There is insufficient management oversight or challenge by IROs where assessments and plans are weak.

There is a lack of clarity among staff about the return interview process for children missing from care and return interviews are not always carried out appropriately. Better joint working is needed between the police and children's social care.

Early help services support more young children to remain at home with their families. Thresholds are understood and applied consistently and children do not become looked after unnecessarily. However, the number of older children who do become looked after is increasing.

Implementation of the Public Law Outline process has helped to improve the timeliness of care proceedings and plans for children to achieve permanency are made quickly. Care plans are reviewed regularly and permanency for children is considered early in the planning process. The local authority is successful in promptly arranging adoption for children when this is in their best interest.

There has been an increase in the number of foster carers recruited but the pool of carers does not fully match the profile and needs of children. Foster carers feel supported and well prepared to foster children.

The children in care council meet regularly and have done some good work to improve experiences and services for children in care and represent their views to elected members and managers. This group does not currently include children living in children's homes or care leavers, and so their voice is not as well heard.

56. The local authority has had some success in its strategy to reduce the number of children in care. Currently 693 children are looked after, a reduction from a high point of 719 in March 2013. The main reason for the reduction is the increased number of children leaving care during 2013–14, compared with 2012–13. Early help services are effective at supporting more young children to stay at home with their families, but are having much less impact on reducing the number of older children who become looked after.

57. The number of 16- and 17-year-olds becoming looked after has increased each year since 2009. Young people aged 16 and 17 now represent over a quarter of all children in care. Action to ensure that this group are well supported is not evident and a small number of older children have drifted back home, without purposeful preparation work to support them and their families.

58. Thresholds for care are understood and applied consistently and this means children do not become looked after unnecessarily. The 'access to resources panel' ensures that alternative support arrangements have been explored before any agreement to a child becoming looked after is made.

59. A small number of children have been placed with parents with a plan to discharge the care order, but have then remained in this situation for a number of years. This has not been challenged sufficiently by managers or by IROs, which has meant that some children are subject to legal orders for too long.

60. The local authority is using the Public Law Outline effectively to reduce the average duration of care proceedings to within 25 weeks against a national average of 31 weeks. Inspectors saw examples of good parallel planning which means that children and young people are experiencing less delay in achieving permanency. Relationships with partners in the family justice arena are positive, with the Children and Family Court Advisory and Support Service (Cafcass) describing the care proceedings work by the authority as realistic, detailed and well planned.

61. The quality of written assessments, care plans and case recording is not good enough and some are poor. The majority of written assessments seen by inspectors do not contain enough detail about the children. Some are not up to date and lack important information, such as changes of placement and contact arrangements with parents. Care plans are completed routinely but are not always specific or detailed enough. Not all plans record children's views and wishes or how they have been involved in the process. Inspectors did see evidence of some plans that were thorough and clearly identified needs, including those which considered religion, culture and heritage, but this is not the case for all children.

62. Not all young people who go missing from care receive a return interview with an appropriately independent person. Sometimes a return interview is with a member of staff from the residential home, which is inappropriate, as the young person may have run away because of something happening at the home. Information from return interviews is not routinely used to plan for the young person's future safety. In September 2014, there were 28 reports of looked after children going missing.

63. When young people repeatedly go missing or are considered to be at risk of sexual exploitation, multi-agency risk meetings are held. Information sharing protocols work well, but responses to children at risk are not informed by a shared strategic protocol, and inspectors saw responses and thresholds applied by the police that were different to those applied by children's social care.

64. Statutory visits to children looked after are carried out within timescales. Most social workers could talk with knowledge about the children they support and could demonstrate that they had spent time with them to understand their wishes and feelings. However, this was not always reflected in case records and plans, which means that information about how children's needs will be met may be lost if workers change. In some cases, chronologies are used to capture important events in children's lives and this is a priority for those cases in court proceedings. Chronologies are used less frequently for children who are not subject to court proceedings, which means that their past experiences are not fully taken into account.

65. Care plans are reviewed regularly and children, parents and carers are well prepared before the review. Children and parents said that they understood their plans and knew what was supposed to happen. There were examples seen in plans that children's cultural and religious needs were being considered thoroughly and that children with disabilities were being supported well in their placements and at school. Care reviews are well attended by professionals and reports are sent in advance of the meeting.

66. IRO caseloads are high, and this means that they do not have enough time to ensure that the plans made at reviews are being implemented on time. IROs do challenge social workers on their practice, but this is mostly on an informal basis, and not always recorded. As a result, it is difficult to see how these situations have been monitored and how often challenges are acted upon. The IRO manager is aware of this issue and has presented a plan to the corporate parenting panel and the LSCB outlining how IRO involvement and influence on children's progress will be captured in future.

67. Children are supported to maintain a good range of flexible contact with their families. Examples seen included basing contact around a family meal, play sessions at children's centres, contact supervised by family members and weekend contact. Telephone, text and 'face time' are used in between face to face sessions to promote contact.

68. Children told inspectors that they feel safe at home and at school and would know what to do if they did not. They know how to complain and were able to give examples of things that had changed because they had raised them with their social worker, such as seeing more of friends. They like their social workers and feel listened to; they have good relationships with them and spend time with them alone. Children said they had opportunities to develop interests, hobbies and friendships outside school. They can bring friends home and spend time at friends' houses.

69. The educational achievement of looked after children requires improvement, as most do not make enough progress over time and results fluctuate from year-to-year. At least half of the children in early years achieve age-related expectations in the early learning goals. At Key Stage 1, although the most recent published attainment performance is in line with looked after children nationally, it has not been sustained in 2014, particularly in writing and reading. At Key Stage 2, despite two thirds of the 2014 cohort having a statement of special educational needs or being supported by a school action plan, they achieved well, with a small minority achieving the higher levels. Attainment at this Key Stage is in line with looked after children nationally.

70. GCSE results have improved over the last three years and are in line with similar authorities. Targeted strategies to improve outcomes show some good impact. For example, seven out of ten young people who received tuition in English and mathematics achieved GCSE grade C or above in these subjects. Nevertheless, the 2014 unvalidated results show a decline, with only 14% obtaining five or more GCSE grades A*-C including English and mathematics. The attainment gap is still too wide because most looked after children are not making more than the expected rate of progress from Key Stage 2 to Key Stage 4. Children placed in schools or settings outside the local authority achieve similar results to those in Bristol.

71. The HOPE virtual school for looked after children in Bristol ensures that the majority of children in care are in good or better schools. Attendance is kept under close scrutiny, but persistent absence at 14% is too high; this is highest in secondary schools and amongst those from White ethnic backgrounds. The number of days lost through fixed term exclusions has fallen, but fixed term exclusions remain high and some groups are over represented, in particular boys, those with challenging behaviour and those from minority ethnic groups. There have been no permanent exclusions for five years. Those pupils missing education are targeted closely to improve their attendance. While the educational provision offered includes 25 hours each week, most have low attendance.

72. Personal education plans (PEPs) require improvement. The action plans do not include clear timescales, and the success criteria are not measurable and do not dovetail well with academic targets. Although a new electronic system is used to monitor the plans, compliance is not good. In 2014, 82% of PEPs were completed; this is well below the local authority's 96% target. Consequently, schools are not rigorously supporting the ambitious targets outlined in their vision for better outcomes. Very little attention is given to evaluating the impact of the use of pupil premium.

73. Permanency planning meetings produce clear plans, which are reflected at reviews. In most cases, practice ensures that children achieve permanency without delay. Inspectors saw a small number of cases where plans lacked detail or did not explain the contingency arrangements. 'Value for money' meetings, which are mainly business-focused, are held for all external placements and contribute to reducing drift by making sure that plans about the duration of short-term placements are clear and that children are moved to a permanent home as soon as possible.

74. Training provided by the local authority for foster carers is good. Foster carers told inspectors that they felt well prepared for the role. They said that their social workers were supportive, efficient and reliable, and responded quickly if asked for help. Some foster carers were unsure of how pupil premium money could be used for activities such as music lessons.

75. Strategic plans are in place to meet placement sufficiency, and internal foster care recruitment has kept pace with the increasing demand. There are now 273 foster carers providing 470 places. A higher proportion of children are placed in foster care than the national average, but despite an improving picture this does not meet the demand for family homes for older children or family groups. Overall, 83% of children in care are fostered. Of these, 62% are placed with in-house foster carers and 38% are placed with carers from independent fostering agencies. These placements are closely monitored both for the quality of care given to children and value for money. There are some in-house foster carers who have had vacancies for several months and the sufficiency issue is not about the number of foster carers but the range, choice and skills of carers available.

76. Performance on short-term and long-term placement stability is good. However, there has been an increase in the number of unplanned placement disruptions for older children, which means that more are experiencing moves in crises where they and their carers are not well prepared. This in turn means that the new placements are at risk of breaking down. The local authority has commissioned a range of services to help support foster carers and prevent placement break down. These services, such as the child and adolescent mental health services (CAMHS) drop-in, are seen as very helpful by foster carers in helping to prevent breakdown and in managing children's behaviour.

77. Of those children placed outside Bristol, the vast majority remain within twenty miles of home, which means that it is easier for children to maintain friendships and contact with their families. These placements are closely monitored and reviewed to ensure that the needs of the children are being fully met. The two young people placed at a distance from Bristol who were visited by inspectors were in homes rated good or outstanding; they were well looked after by their carers and were making good progress.

78. The health needs of children becoming looked after are assessed promptly. The proportion of those who received an annual health assessment during 2013–14 was above the England average at 91%. Improvements have been made to make sure that children have up-to-date dental checks and immunisations, including those children who live outside the Bristol area. Their health needs and treatment are monitored at weekly meetings held by the specialist looked after children nurse. A wide and innovative range of services support and promote looked after children's mental health and well-being, including individual and group work and an extended CAMHS programme which provides a seamless service through to adulthood.

79. The active children in care council meets regularly and has a core membership of some 25 young people. The group has undertaken a variety of activities, such as sharing their ideas on keeping contact with brothers and sisters and working with IROs to make reviews more interesting for young people. The children in care council also has representatives on the BSCB shadow Board so their experience shapes the BSCB strategy. Children living with foster families are well represented on the children in care council but children living in children's homes are not. There is a missed opportunity to involve children in residential homes in this key forum.

**The graded judgement for adoption performance is that it is good**

80. When it is decided that children need a permanent home, adoption is considered at the earliest possible stage. The adoption service captures information on children where adoption may be the plan and ensures that their progress is closely tracked so that there is no unnecessary delay. The local authority's performance, measured against the 2010 to 2013 adoption scorecard, is good, and shows children in Bristol move quickly into their permanent families. The average number of days between a child entering care and being placed with their adoptive family is 559. This is 88 days quicker than the England average and 79 days quicker than the authority's statistical neighbours. Once the court has agreed that a child can be placed for adoption, a family is found within an average of 194 days, which is better than the England average of 210 days.

81. From 2010 to 2013, the percentage of children looked after being adopted in Bristol, at 13%, was equal to the England average but lower than statistical neighbours. In 2013–14, 50 children were adopted, which is more than double the number of adoptions in 2012–13 and represents good progress.

82. When adoption is not considered to be in the best interests of children, a good range of alternative permanence options are available for children who cannot remain with their birth parents, such as special guardianship orders (SGO). In 2012–13, 31 SGOs were made to family members or former foster carers, and this has increased to 46 in 2013–14.

83. At the time of inspection, 13 children had a plan for adoption and 13 sets of adopters were without a match. Good work is undertaken to engage and commission adoption agencies for harder to place children. Bristol is part of the South West Adoption Consortium, which provides matches for children and adopters outside Bristol. The service participates in regular exchange days and uses adoption publications, 'Be my parent', 'Adoption Today' and the national adoption register.

84. The adoption service makes good efforts in family finding activity for children with developmental uncertainty and has been successful in placing children with families. Family finding for children with complex needs often takes longer and this commitment to finding a permanent family inevitably affects scorecard performance.

85. Recruitment activity is supported by a marketing and recruitment officer for both prospective adopters and foster carers, using a wide range of media, advertising and attendance at community events to raise the profile of children needing adoption. Recruiting sufficient adopters remains a challenge, but recent campaigns have led to an increase in prospective adopters contacting the adoption service.

86. Good use has been made of the Adoption Support Grant by recruiting three additional adoption social workers. The regional consortia have been used to good effect to provide adopter preparation training in order to free up additional adoption social worker time for assessment and post-placement support. The grant has also been used to purchase additional medical adviser time and to fund a Court Manager post to focus on reducing PLO timescales. This has contributed to bringing timescales for care proceedings down from 61 weeks in the first quarter of 2012–13 to 25 weeks in the first quarter in 2014–15.

87. The Adoption Panel does not routinely see life storybooks at the matching panel, which is a missed opportunity. This would enhance the panel's quality assurance role and provide an oversight on the quality and consistency of the books.

88. The Adoption Panel benefits from an experienced chairperson and panel adviser and is well administered. Panel membership reflects the diversity of Bristol's population. Legal and medical advice is clear, and prospective adopters are able to meet with the medical adviser to discuss health matters. Agency Decision Maker decisions are timely and, from evidence in Adoption Panel minutes, there is appropriate challenge from panel members.

89. The quality of prospective adopter reports and matching reports seen is good and they contain clear analysis and detail. The quality of child permanency reports is more variable, although panel members report that the quality is improving. One panel member reported that it is '… like the child is in the room'. The panel provides direct quality assurance feedback to social workers and this is recorded in detail in panel minutes.

90. The panel chair meets regularly with departmental managers to discuss national developments and local issues, but the panel chair does not provide an annual report on adoption activity and information is not collated and analysed. This is a missed opportunity for the adoption service to reflect on its own service from the viewpoint of the independent panel.

91. There are annual training events for the panel, which include training with social workers. One recent event was on learning from disruption of placements.

92. The local authority is in the process of developing a 'fostering to adopt' project with a children's charity and has one 'fostering to adopt' placement. All prospective adopters are asked if they are willing to become approved as 'foster to adopt' carers.

93. Post-adoption support is currently provided to 61 families. Adopters spoke very positively about the quality and range of support available, which is responsive to their requests for advice or support. One adopter spoke of appreciating the therapeutic parenting group and the supportive network of other adopters that had developed from the course. Quarterly newsletters are sent out to all adopters and there is an annual fun day for adopters and their children. Events run throughout the year and include two events for teenagers. Each year there are two themed support events for adopters. One recently focused on single adopters and another is being arranged for same sex couple adopters.

94. Adopters and their children benefit from having a very stable, expert and experienced team of adoption social workers. One adopter reported that the workers have a good knowledge of the families so she does not need to repeat her story if she contacts the service for support.

95. Adoption disruption rates are low with only one disruption in 2013–14, which was followed up with a very detailed and thorough analysis and the learning disseminated via discussion in team meetings.

96. The adoption statement of purpose was last reviewed in August 2013. It is now due for review. The statement of purpose is informative and explains the process of adoption clearly. It lists the range of services and includes services for people who are considering adoption or who have been affected by adoption.

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

97. Outcomes for young people preparing to leave care and live independently are poor. Most pathway plans are ineffective, lack analysis and do not set out clear actions that will drive forward good outcomes for care leavers. There was little evidence of management oversight in the pathway plans seen. This means that young people are not helped to understand their changing needs and make secure plans for their future. Some young people who spoke to inspectors did not know about their entitlements to help and support, for example, access to funding for setting up a home or access to advocacy services to help them have a voice and be heard.

98. The staff team is stable and experienced in working with young people but there is no robust system to monitor the impact that the service has on outcomes for young people. Caseloads in the specialist Care and After team are high, which means that workers do not have sufficient time to spend with young people or support them to become independent adults.

99. The percentage of care leavers who are not in education, employment or training is too high, at 50%, and there is a lack of coordinated action at strategic and practice levels with partner agencies to address the causes of this. However, the local authority provides good support to 24 care leavers at university, and Learning Partnership West is having some success in engaging young people in training and employment opportunities, but this is a new project, which has yet to demonstrate improved outcomes.

100. Bristol has 461 care leavers. In addition, 192 young people aged 16 and 17 are looked after, and most of them are eligible for care leaver services. The Care and After team is responsible for some 350 care leavers, the others remaining in Vista (the social work practice) and other teams. The children with disability team are supporting a small number of young people to make the transition to adult social care.

101. Case records on care leavers' files are often incomplete and do not demonstrate that comprehensive risk assessments have been undertaken. This means that the local authority does not know how many care leavers are at risk from drug or alcohol misuse, for example, and therefore does not know what support they may require to address these needs.

102. The local authority is currently not in touch with 129 young people, just over a quarter of its care leavers. This means that the local authority cannot be sure that these young people are safe. Young people are encouraged to keep in touch with their support workers once they have left care through the provision of a drop-in service, a web site and a free phone number to help them to access a range of support services. Staff also try to keep in touch using social media, texts and phone calls. Notwithstanding these initiatives, arrangements to keep in touch with care leavers are ineffective as too many are not seen or well supported.

103. The local authority reports that the large majority (92%) of the care leavers they are in touch with live in suitable accommodation. However, some young people told inspectors that they were unhappy with their accommodation and did not feel it was in a safe area. Some said that their accommodation had restricted their ability to study. Not all were able to choose who they shared accommodation with. Five young people who have ceased to be looked after are currently known to be living in houses of multiple occupation.

104. There is a growing range of accommodation and housing options for young people. In partnership with housing providers, the local authority has arranged individual supported housing packages for a small group of vulnerable young people

105. Over 40 young people are benefiting from the Staying Put policy and continue to live with their foster carers after the age of 18, and a small number of such placements have converted to supported lodging schemes.

106. Support for care leavers to manage their health and promote healthy living is not consistently available and there is no health passport scheme. Young people are reminded to register with a doctor and dentist but are not provided with a copy of their health records. This means they may be unaware of important details of their health history when seeking treatment. Some personal advisers know young people well and can describe the work they have done with them to promote well-being and to access health services, but this is not well reflected on case files. There are some good examples of work to promote the mental health of young people leaving care, such as the extended CAMHS service, which young people over 18 can access.

107. The children in care council currently has no members who are care leavers. This is a missed opportunity to hear their voice. There is a regular care leaver forum, which provides some opportunity for engagement.

| Key judgement | Judgement grade |
| --- | --- |
| Leadership, management and governance | Requires improvement |

**Summary**

The local authority has a good understanding of the main issues for children and their families in Bristol and of the strengths and weaknesses in the services it provides. The new Strategic Director for People and his senior team have provided strong leadership through the 'Children First' reshaping of services programme. Some significant progress has been made, for example, in implementing a good range of early help services, which is having a positive impact for some children and families. Governance arrangements are secure between the City Director, the Strategic Director for People and elected members.

The local authority has worked well with other agencies to re-shape services, with a strong focus on children. It is an influential partner in helping the Bristol Safeguarding Children Board to develop a culture of professional challenge and in raising awareness and securing additional funding for services for children at risk of CSE. Training for staff in the 'Signs of Safety' approach is beginning to show some positive results, with better working relationships with families, and children clearly being listened to.

However, some key strategic plans are out of date or not yet available. The Children and Young People's Plan 2011–14 has not been updated in line with the development of local need and the re-shaping of services. There is no overarching strategic plan covering CSE or children who go missing from home or care. This means that services and practice are not well coordinated or effective between agencies.

The corporate parenting plan does not provide the focus and drive needed to improve services for looked after children and care leavers.

Improvements are needed in relation to the number of care leavers accessing education, training and employment and the availability of suitable foster placements for older children. The local authority is not in contact with many care leavers and it does not know if they are safe.

At present high caseloads in some teams limit social workers' ability to build meaningful relationships with children, fully assess their needs and plan effectively to improve their outcomes. This is a continuing concern, which was raised by inspectors at the time of the last Ofsted inspection in 2010.

Improvements to the virtual school that monitors the education of looked after children are recent and are yet to have an impact on improving educational attainment.

108. The relatively new senior leadership team, including the City Director and the Strategic Director for People, has ensured that there is sufficient management capacity and clear lines of accountability; they know what the key strengths and weaknesses are in the services they lead. However, while significant progress has been made against some priorities, such as early help to families, insufficient progress has been made against known significant weaknesses.

109. Outcomes for looked after children and care leavers remain poor. In particular, the proportion of care leavers in education, training and employment is unacceptably low at 50%. The local authority has not done enough with sufficient urgency to improve this situation. During the course of the inspection, a composite plan of existing actions to address poor outcomes for care leavers was collated by the local authority. However, as a set of disparate actions, they do not comprise a strong joined up plan and lack focus.

110. The Strategic Director for People and his senior team have provided strong leadership in reshaping services for children and young people. This includes the introduction of the First Response Team (FRT) to handle all initial contacts with children's services, and is about to move social work staff into smaller 'social work units'. This is intended to result in fewer changes of social worker for children. Influential leadership by the City Director and Strategic Director for People is also evident in supporting a growing culture of professional challenge within the Bristol Safeguarding Children Board (BSCB).

111. The City Director, senior leadership team and elected members, including the elected Mayor and the Assistant Mayor (who is the lead member for children), have ensured that there is a structure in place, both within the local authority and with partner agencies, to support improvement. This includes adding extra senior management capacity in children's services, introducing rolling three-year budgets to support planning, and the creation of a Children and Families Board (C&FB) to shape strategic inter-agency service planning and keep it sharply focused on children. Extra multi-agency funding secured for the Barnardo's Against Sexual Exploitation Team (BASE) exemplifies how Bristol City Council has worked hard to focus planning for children across agencies and has secured improvements in some important areas.

112. The local authority demonstrates its commitment to political, officer and partner scrutiny through the regular meetings of the people's directorate scrutiny commission. Minutes show elected members ask appropriately detailed questions of officers, for example on the educational attainment of Looked after children. The lead member has used her role on the scrutiny commission to challenge the people's directorate about how it is responding to CSE in the light of the Jay report and to maintain a sharp focus on this area.

113. The Joint Strategic Needs Assessment (JSNA), updated this year, clearly reflects local need and demographics and is aligned with the priorities of the C&FB. However, the current Children and Young People's Plan 2011–14 has not been updated, and there is no multi-agency strategic plan to shape the delivery of services and to act as a yardstick against which success can be measured.

114. The C&FB has been central to the creation of a comprehensive and cohesive early help offer for families in Bristol. The success of the Government's 'Troubled Families Initiative' has resulted in Bristol being chosen as an early implementer of a new, extended, five-year programme.

115. As a 'corporate parent' the local authority has not ensured that children in care make fast enough progress in closing the educational attainment gap between them and all children. With 13 out of 14 personal education plans seen by inspectors judged as requiring improvement, support for these children is not good enough. Improvements have been made to the structure and focus of the virtual school, including the appointment of a new head teacher, but this has not yet made sufficient difference for children.

116. The specialist commissioning plan for looked after children reflects current needs and has helped make sure that recruitment and commissioning arrangements provide a sufficient range of suitable placements for most children and young people. The local authority places a high proportion of its looked after children with its own foster carers and within 20 miles of their families. There is good consideration of matching children with carers of a similar ethnicity and culture. However, there are insufficient skilled foster carers to provide choice and meet the demand for places for older children and family groups. The local authority faces a challenge in meeting the demand for foster homes from the growing number of looked after teenagers.

117. Information collated by the local authority on the number of children who are at risk of child sexual exploitation (CSE), or of going missing from their family homes or care is limited and lacks analysis. Although Barnardo's and the police undertake data analysis, this is not routinely shared with either the local authority or the LSCB. Information from return interviews with children who have been missing is not used to inform planning to keep individual children and young people safe, nor is it collated and analysed to identify key themes that could help with strategic planning to tackle these problems. Work in this area by children's services and the police is not well joined up. There is no over-arching strategy on CSE and children going missing to help shape activity, assess impact and develop services. The partnership has shown determination to disrupt CSE activity and pursue prosecutions. There are examples of good practice locally which have resulted in disruption of activity and lessening of risk. Prosecutions have been successful. There are also initiatives to divert young people from gang association including 'Bright outlook'. However, there has been no systematic evaluation of this activity.

118. The local authority's performance and quality management system does not provide data on all of the key priorities, including care leavers in education, training or employment, improving the poor quality of pathway plans and improving the quality, number and review frequency of child in need plans.

119. The local authority's audit framework enables managers to have information about the quality of services to consider, alongside data about numbers and timeliness. This has been used to good effect to improve performance in some important areas; for example, in reducing the number of children who need to remain on child protection plans for more than two years, and in significantly improving the timeliness of initial child protection case conferences, which is now better than the average for similar local authorities.

120. Performance management is also informed by feedback from parents and carers, which shows an improvement over the course of this year in how well they feel social workers work with them. Although there is some evidence of the learning from complaints being used to improve services, the delay in producing the 2013–14 complaints annual report, which remains unpublished, necessarily limits this. The speed with which complaints are dealt with has declined and currently 45% of 'stage one' complaints are not dealt with within the statutory timescale.

121. The local authority effectively involves children in some important decisions about services. Young people from the children in care council regularly attend the corporate parenting board and are actively engaged in interviews and shaping service specifications as part of the recent re-commissioning of foster placements. In March this year, the youth parliament and 'young inspectors' attended a session on the re-shaping of the youth links service and will be invited to attend a follow-up session in March 2015. However, the local authority has not used feedback from children in reviewing the quality and impact of services. The opportunity is missed to use feedback from the independent chairs of child protection conferences or the advocacy service to understand how well children are involved and listened to.

122. In some teams, high caseloads have affected social workers' ability to consistently complete social work tasks and build stable and meaningful relationships with young people. In a small number of cases, newly qualified social workers have been working with too many children and with situations that are too complicated for their level of experience. Social workers report that managers are readily available for guidance and support and case direction is evident on file in most cases. However, supervision files show very little evidence of reflective discussion and insufficient evidence of targeted discussion in relation to professional development.

123. The local authority has a stable workforce, with low use of agency social workers. It is developing the workforce, with a comprehensive package of training and support for new social workers and training in the 'Signs of Safety' tools and methodology for social work staff and those in other agencies who deliver the early help offer. This new approach is a strength, which is beginning to have a positive impact on how professionals work with families and listen to the voices of children. A recent successful bid to the Department for Education's 'Innovations Fund' will provide extra funding to extend the use of this innovative approach.

124. Staff development and improvements in the quality of practice are well supported by the Principal Social Worker. This worker provides support to new social workers through focused training in key areas such as the new 0-25 integrated service for disabled children and young adults. She also provides feedback to senior managers from front line staff and sits on the local Family Justice Board. This helps to ensure that improvements achieved in the timeliness and quality of work with children who are the subject of care proceedings are maintained, by linking strategic ambition to front line practice.

125. The local authority delegates its work with up to 140 looked after children for whom the plan is to remain in care to a 'social work practice' called Vista. Children receiving a service from this practice benefit from having social workers who typically have smaller caseloads than those directly employed by the local authority. This helps give social workers more time to forge meaningful relationships with young people, which in turn supports clearer assessment and planning. The quality of practice received by these young people is of a similar standard to that of the local authority, and there is little evidence to show that the Vista service adds value in improving outcomes for care leavers. The local authority is currently reviewing its commissioning arrangements in this area.

## The Local Safeguarding Children Board (LSCB)

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

### Summary of findings

**The LSCB requires improvement because:**

*Business planning*

- The Board is not yet able to consistently influence and support good safeguarding outcomes for children across the partnership. It is not sufficiently informed about safeguarding practice.
- While there are examples of effective multi-agency arrangements, the business plan is not specific enough or focused and this means that some work is not coordinated effectively across the partnership.

*Performance information*

- The performance report card does not include sufficient evaluation of partnership performance to enable effective scrutiny or the monitoring and analysis of trends.

*Quality and evaluation*

- Although the LSCB is informed about the safeguarding activity of partners, it does not sufficiently scrutinise partners' performance to measure the impact of the Board's work and inform future priorities.
- The LSCB does not yet evaluate the impact of training on practice to enable it to identify impact or improvements in outcomes for children.

*Policies and procedures*

- The Board does not have a detailed understanding of the quality of multi-agency practice with children at risk of CSE or those children who go missing. There is no multi-agency strategy for children at risk of sexual exploitation. The 'children missing from home and care' policy has not been updated to reflect changes in guidance.
- Although a domestic abuse protocol has now been developed, there is not yet a shared understanding of risk in such cases between the police and children's social care.
- The LSCB does not routinely review local policies and procedures nor evaluate their impact on practice.

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## What does the LSCB need to improve?

### Areas for improvement

*Business planning*

126. Develop a single overarching plan for the delivery of business priorities that is outcome-focused and measurable. This should incorporate findings from the Board's self-assessment and Section 11 audit.

127. Implement plans to restructure the Safeguarding Business Unit to improve support for the delivery of safeguarding activity across the partnership.

*Performance information*

128. Develop the dashboard of multi-agency data to improve the depth of performance information and use comparative quarterly data to enable effective monitoring and analysis of trends.

129. Improve the depth of performance information about children missing from home and care, in particular whether appropriate return home interviews have been undertaken.

*Quality and evaluation*

130. Ensure that the annual report provides a coherent overview, analysis and evaluation of multi-agency safeguarding activity and uses this effectively to inform future planning priorities.

131. Coordinate the programme of single and multi-agency audits to avoid duplication of work and to measure the impact of safeguarding activity on front line practice over time.

132. Improve the quality of multi-agency audits by ensuring that a sufficient sample size is used to make an evaluation of the impact of learning on front line practice.

133. Develop a systematic review of LSCB policies and procedures and establish a process for evaluating impact. In particular, review the adult mental health policy.

134. Develop and implement the learning and improvement framework (currently in draft form) and include within it how the views and experiences of children and families are to be captured.

135. Analyse single agency training requirements to inform the multi-agency training programme and develop measures to evaluate the impact of training on practice.

*Policies and Procedures*

136. Produce a multi-agency strategy for the protection of children at risk of sexual exploitation.

137. Update the 'children missing from home and care' guidance to include missing and absent definitions and provide clear expectations for conducting safe and well checks and appropriate return interviews; this should link to the multi-agency CSE strategy.

138. Implement the domestic violence information sharing protocol within schools to ensure a shared understanding of risk between police, children's social care and other partners.

## Inspection judgement about the LSCB

139. Through the Bristol Interagency Safeguarding Group, the City Director and the people's directorate leadership team are helping to strengthen the effectiveness of the BSCB. This has been achieved through setting appropriate priorities and building a culture of professional challenge between strategic partners at the highest level. This group is attended by the chair of the BSCB, with good representation from other strategic Boards such as the Health and Well-being Board and the Children and Families Board. However, the BSCB does not sufficiently influence these Boards to ensure a robust focus on safeguarding.

140. Following a four-month period in which the board's established vice chair acted as interim chair in addition to her full time role, the experienced, newly appointed chair is reviewing priorities in preparation for the next business cycle. Board membership has been reviewed to ensure the most appropriate level of attendance and influence by partners. Good consideration is given to the engagement of faith groups, through regular meetings and a multi-faith action plan to raise awareness of safeguarding responsibilities within these groups.

141. Core membership of the Board meets statutory requirements and lay members make a positive contribution to the Board through community discussion groups. The business manager has challenged the poor attendance of education partners at Board meetings and this has led to better attendance and significantly improved the contribution of schools to Board activity. For example, educational representatives have contributed to the development of a domestic violence protocol and work with the Children and Young People's Shadow Board.

142. Children and young people's participation in the safeguarding agenda in Bristol is effectively prioritised by the BSCB. Young people, as members of the shadow Board, actively influence the delivery of services at a strategic level and feed their views directly to the Board and subgroups. The Board acts on recommendations made by the Shadow Board to provide training about bullying for school staff, peer mentoring in schools to raise awareness of support for incidents of self-harm and the strengthening of related policies. There has also

been a review of the participation of children in recruitment processes in a Bristol NHS Trust.

143. The BSCB Business Plan 2014–15 focuses on the key areas for improvement, but there is no single overarching plan to support its delivery. Actions are attributed to the various sub-groups of the Board but they are not outcome-focused or measureable. The Board has completed a self-assessment of its effectiveness that identifies the areas for improvement, but the evaluation of this has not been incorporated into business planning, which limits its impact.

144. Much work has been undertaken by the Board to cover an ambitious programme of safeguarding activity and to strengthen the Board's function, but there have been some delays in the implementation of tasks set out in the business plan. Delays include the implementation of the domestic violence information sharing protocol in schools, and updating the 'missing from home' and 'missing from care' guidance.

145. The new chair of the Board is rightly reviewing the activity of the Board to ensure that the business plan is achievable. Positive action has recently been taken to improve the business functioning of the Board, with agreement reached for a restructure and additional resources. These include additional working days for the chair to support improvement, closer monitoring of sub-group activity by the executive Board, and a review of the membership and terms of reference of the sub-groups to ensure broader partner engagement and a shared understanding of the delivery of safeguarding priorities.

146. Plans are in place for the CSE working group to become a sub-group of the Board in order to strengthen scrutiny and accountability in this important area. The Board is also planning to review the financial contributions of partners to ensure a more equal contribution by all agencies and to strengthen the Board's independence.

147. The BSCB launched the new threshold document in February 2014, outlining the threshold for need, risk and access to services. This document is now well understood by partner agencies and has led to a more consistent application. Partners report that the launch of the threshold document was a 'dramatic turning point', improving relationships with children's social care and helping professionals to understand how to access appropriate levels of service.

148. Positive work has been undertaken by the substance misuse and by the female genital mutilation (FGM) working groups in relation to raising awareness, the development of multi-agency protocols and the provision of training. Work to raise awareness and prevent FGM under the Bristol Model is highly effective in engaging with the community and particularly young people, with initiatives such as the FGM game used in schools, training undertaken with the East African community locally and an international conference on FGM, which 300 delegates attended. The Board has helped to coordinate multi-agency support for the innovative Community Rose Clinic for victims of FGM, which is

commissioned by Bristol Clinical Commissioning Group and opened in the city in 2013.

149. The BSCB does not yet provide a robust and rigorous evaluation of local safeguarding performance. The report card encompasses a broad range of multi-agency data, but does not incorporate comparative data from previous quarters or provide sufficient depth of information about, for example, CSE, children missing from home or care, domestic abuse, or caseloads. This reduces the effectiveness of monitoring, analysis and the impact on front line practice. Challenge by the Board is beginning to be seen. For example, the Board established that improvements were required in the quality of data provided by the police. As a result of the Board's challenge the police are now in the process of reviewing and strengthening the data they provide to the Board.

150. A broad range of relevant multi-agency reports is presented to the Board by partner agencies to facilitate the monitoring of safeguarding activity. However, the Board does not make good use of this information to plan the delivery of high quality services. For example, the Board receives verbal information from the police on CSE, but no regular written reports analysing CSE activity. The absence of coordinated information and evaluation limits both strategic and action planning.

151. The BSCB Annual Report 2012–13 is weak, with little analysis of the effectiveness of the Board, and it does not sufficiently inform future priorities. The Annual report 2013–14, although still in draft form, is an improvement but it is too focused on children's social care data, rather than an independent evaluation of the effectiveness of partners' work to safeguard children.

152. The learning and improvement framework is currently under review and the revised draft presents a clear framework for outlining how learning from serious case reviews, audits, case reviews and the work of the Child Death Overview Panel will be monitored and evaluated for impact. In its current form, the framework does not describe how the views of children, young people and their families will be captured.

153. An appropriately focused and broad range of multi-agency training is available for all staff and partners and this is well attended. Action-learning sets, briefings and area network meetings take place regularly. Learning from serious case reviews and from the schools safeguarding audit has been used well to inform multi-agency training. This includes training on 'disguised compliance', advanced domestic abuse and safer recruitment. 'Signs of Safety' training is also provided for all agencies to consolidate this approach. However, the current training strategy is not informed by an evaluation of single agency needs. The Board plans to implement an evaluation of the impact of training on improving practice but does not yet rigorously evaluate the impact of training. Work is underway to achieve this.

154. A well-established programme for multi-agency auditing is in place, but audits of thresholds for missing from home and care, self-harm, and non-engaging families are not robust. In some audits, only two cases have been reviewed and school representatives have not been involved, which reduces multi-agency learning. The Principal Social Worker is developing a multi-agency audit tool to improve consistency and quality. Single- and multi-agency audits are not effectively coordinated, which causes duplication of effort and limits the opportunities for learning. The most recent audit on CSE is much improved in quality and is appropriately focused around the 'See me, hear me' framework. It draws up themes for improvement and a clear plan of multi-agency action. This includes developing a multi-agency CSE strategy and reconvening high-level multi-agency meetings about children at risk of CSE.

155. Good arrangements are in place for the development, review and delivery of multi-agency child protection procedures through the South West Consortium but policies developed at a local level by the Safeguarding Business Unit are not subject to routine review, which means that some are several years out of date, for example, the adult mental health policy. The Executive Board has prioritised policies and procedures for review during this business cycle, but the impact of policies and procedures on front line practice is not yet systematically evaluated.

156. Members of the Board and its sub-groups demonstrate a clear understanding of the Board's priorities and a shared responsibility for safeguarding, and this extends across the partnership. However, there has only been one Section 11 audit to measure the effectiveness of safeguarding in agencies since the Board's inception, and findings arising from this very recent evaluation, in October 2014, have not yet been implemented. The safeguarding schools audit is well established and evaluative, and it shows improvement in safeguarding in schools since last year particularly in relation to safer recruitment and a raised awareness of the LADO role.

157. Effective arrangements are in place for managing and learning from serious case reviews through briefings, team meetings, and a well-attended multi-agency conference held in July 2014. Recommendations made by the National Panel are taken into account. Action plans are monitored effectively, with good use of a template to record exceptions arising out of the delivery of multi- and single-agency action plans. The Board has adopted the Social Care Institute for Excellence (SCIE) methodology, which speeds up learning and engagement of front line practitioners. Learning from serious case reviews and multi-agency training has led to improvements in front line practice. For example, training delivered to practitioners in adult services has raised their awareness of service users and patients with responsibility for children.

158. Arrangements for the management, oversight and learning from child deaths are well embedded. The West of England Child Death Overview Panel appropriately focuses on local as well as regional issues and demonstrates effective monitoring and evaluation, including an audit of the rapid response

process. Learning from child deaths is used to inform the development of services, for example, supervised methadone consumption and the welfare of children who are educated at home. There are clear processes for reporting to the BSCB, including a protocol for cases that are, or may be, subject to a serious case review.

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# What the inspection judgements mean

## The local authority

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

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

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

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

## The LSCB

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

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

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

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

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## 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 six of Her Majesty's Inspectors (HMI) and two additional inspectors from Ofsted.

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