Southampton City Council

Inspection of children's social care services

Inspection dates: 18 November 2019 to 29 November 2019

Lead inspector: Nick Stacey
Her Majesty's Inspector

Judgement	Grade
The impact of leaders on social work practice with children and families	Requires improvement to be good
The experiences and progress of children who need help and protection	Requires improvement to be good
The experiences and progress of children in care and care leavers	Requires improvement to be good
Overall effectiveness	Requires improvement to be good

Progress in improving services for children in Southampton since the last inspection in 2014 has been uneven and too slow. Some children benefit from skilled interventions and direct work that reduces risks to them and improves their daily lived experiences, but many do not. The overall quality of social work for children who are the subjects of statutory plans and who are looked after by the council is not consistently effective. Inspectors alerted managers to a small number of children who had not been adequately safeguarded. The frequency and regularity of management oversight and supervision of social workers has improved, but many frontline managers do not concentrate enough on the impact and progress of direct work with children in improving their safety and well-being. Some young people leaving care are inappropriately placed in bed and breakfast arrangements.

Applying consistent and appropriate management decisions of incoming contacts and referrals concerning children in the multi-agency safeguarding hub (MASH) has been difficult. This challenge was amplified by a very high and unexpected increase in referrals that commenced approximately a year ago and persisted until autumn 2019. This surge in referrals resulted in a substantial increase in the volume of

children referred to undergo statutory assessments, and in the numbers of children subsequently placed on children in need plans. Nevertheless, most children and families now receive a prompt and proportionate response to contacts made to the MASH. However, more work is required with partner agencies to improve the appropriateness and quality of referrals, particularly from the police.

Substantial improvements have been made in services for care leavers and in developing an effective, comprehensive and integrated network of early help and prevention services. As a result, more children and families receive skilled help quickly. Disabled children, and children who go missing and are at risk of exploitation, receive effective help. Support for children on the edge of entering care is more effective. Senior managers have retained a largely stable and relatively experienced establishment of frontline social workers.

What needs to improve

- Social workers need to build longer term uninterrupted relationships with children so that their plans are progressed.

- Better management advice for social workers on how to undertake direct work with children and regular reflective discussions on their progress.

- The quality of assessments and plans to ensure that all children get the right help quickly and that its impact is clearly measured.

- Decision-making in the MASH consistently adheres to local threshold guidance and children do not experience unnecessary statutory assessments.

- The use of bed and breakfast arrangements for care leavers aged 18 years and above and children aged 16 and 17 years is discontinued.

- The widespread and inappropriate use of child safety agreements with parents in circumstances when children's exposure to domestic abuse is a primary safeguarding concern.

The experiences and progress of children who need help and protection: Requires improvement to be good

1. A comprehensive, integrated early help and prevention service provides effective and timely support to children and their families. Children with more urgent needs are seen quickly by a rapid response service which provides an initial six-week programme to address many of their unmet needs. Curious and knowledgeable practitioners work alongside families to effect change and improve children's daily experiences. When risks to children increase, they are promptly recognised and, when necessary, are stepped up to statutory services to ensure they are fully addressed, and they are safeguarded as necessary.

2. Most children and families receive a prompt and proportionate response to enquiries and referrals to the MASH. The MASH benefits from the co-location of a wide range of partner agencies, promoting easy and quick information-sharing that informs subsequent recommendations and decisions. Referral thresholds are not always well understood and applied by partner agencies, and this is compounded by some inconsistent decisions by managers in the MASH. This results in a small number of children not receiving the right level of help.

3. A large increase in referral decisions made in the MASH over recent months has resulted in lengthy delays in completing assessments. Consequently, this has led to protracted delays in help being provided for many children, and this is further compounded by changes of social worker for some. These children have been left for too long at potential risk of further harm.

4. The quality and type of referrals made to social care are not always appropriate or well informed, particularly those from the police. Pre-referral triaging is slowly improving, but MASH staff still devote too much time screening out unnecessary contacts. Consent from families to share information is appropriately sought and overridden by managers when necessary.

5. Responses by social workers to children at immediate risk are mainly prompt and rigorous. Concerns for children's safety and welfare arising out of hours are also addressed quickly and proportionately. Multi-agency strategy discussions are held swiftly when initial risks are identified; children are seen promptly and decisions are well evidenced. Timely medical examinations are arranged when required. However, a small number of children experience delays in being seen during subsequent child protection enquiries. When strategy meetings are convened at a later stage in the assessment teams, these discussions do not always feature all involved agencies contributing to decisions about risks and the next steps. Most child protection enquiries are completed within timescales and case records reflect strong partnership work and information-sharing. For a small number of children, identified risks

should have been considered in an initial child protection conference. The local authority responded appropriately to queries referred by inspectors.

6. The quality of assessments and social work reports for child protection conferences reports is mixed: weaker assessments are not always easy enough to understand for families and children, are often significantly overdue and do not portray the voices and experiences of children clearly enough. Evaluations of risks, protective factors and strengths are superficial and feature poorly evidenced recommendations. Chronologies are routinely compiled and offer some sense of children's histories, but many are out of date and do not highlight major changes and decisions. Stronger assessments are underpinned by balanced analysis that informs proportionate recommendations for continuing professional work. Children's identities and social contexts, including social isolation, ethnicity, poverty and family identity, are rarely explored. Efforts to engage fathers are apparent in some, but not all, assessments.

7. Children who undergo assessments and receive support from a range of specialist teams benefit from thorough evaluations of their circumstances and skilled and creative interventions. Incisive parenting assessments provide a solid base for indicating parental capacity to provide sufficiently safe, nurturing parenting and well-formed recommendations for continuing work. Protective parenting work helps parents better understand the harmful cumulative impact of domestic abuse, parental substance misuse and mental illness on their children. Effective edge-of-care work prevents some children's circumstances deteriorating further, enabling them to safely remain with their families. For many children, these interventions lead to significant improvements in their everyday lives at home.

8. A small number of children wait too long for pre-proceedings to be started or are held in the pre-proceedings phase for too long. However, the majority are timely and appropriately concluded. The quality of letters to parents differ. All letters document concerns and expectations, but some could be improved using plain and simple English. The pre-proceedings phase ensures that most critical assessments are completed. Early permanence planning is widely evident, and plans are regularly reviewed.

9. Some social workers in the assessment and protection and court teams (PACT) do not always fully appreciate the accumulating risks to children arising from domestic abuse, parental mental ill health and substance misuse. A lack of attention is paid to parental histories, repeated referral patterns and the potential for significant harm to children to persist and worsen. A wide range of effective services are available in the city to support children, but they are not always used. Child safety agreements with parents are used routinely by social workers, but most are not suitable instruments to mitigate very serious concerns.

10. Many children are supported to attend, or have their views represented and heard through a 'champion' at child protection conferences. The quality of child protection and child in need plans varies widely. Some include broad overarching outcomes that are too vague, or irrelevant outcomes and gaps in identified needs. Timescales for completing actions are not always stipulated. Other plans are more focused and goal orientated. Core group meetings take place regularly, are well attended and are largely effective in developing and reviewing plans to ensure they reduce risks and address children's unmet needs.

11. The frequency and purposefulness of visits to children is also mixed. Some children are not visited in accordance with timescales, or are seen by duty social workers who are unknown to them due to changes in their allocated social workers. These features significantly impede the quality of social work relationships with children and the progress of work. Other children benefit from regular visits, proportionate to their circumstances, from social workers who are interested in them and know them well. These social workers often undertake some creative and insightful direct work, tangibly progressing children's assessments and plans.

12. Arrangements to manage allegations and concerns regarding professionals and volunteers working with children are timely, comprehensive and effective. Services for homeless and highly vulnerable 16- and 17-year-olds are well managed, but their level of vulnerability is not always understood, meaning that not all of these children are appropriately supported through children in need plans.

13. Notifications of children living in private fostering arrangements to the local authority are often late, indicating a lack of awareness from some universal services. Private fostering assessments are child-centred and make appropriate recommendations. Children are seen regularly and on their own. However, when safeguarding concerns arise for children, particularly vulnerable adolescents, they are not always sufficiently understood and addressed.

14. Arrangements for vulnerable groups of children who go missing and who may be at risk of exploitation are well developed and effective. A specialist missing, exploitation and trafficked team (MET) quickly sees most children who go missing within 72 hours and offers effective direct work to support children and their families. Effective return home interviews highlight critical 'push and pull' factors and a clear analysis of risks. This intelligence is used to inform subsequent actions to protect children. A detailed tracking tool is used well by managers to review the impact of actions.

15. Disabled children in need of help and protection are well supported through an effective multi-disciplinary team. Good-quality assessments identify children's needs, resulting in targeted interventions to meet these needs.

Social workers use imaginative approaches to working alongside children to gain their views and understand their day-to-day experiences.

16. Local authority systems to keep an overview of children not placed full time in school are complex but suitable. Useful work has recently been done to develop clear strategies and procedures around elective home education, providing parents with helpful information about their roles and responsibilities. This is also enabling the local authority to be vigilant about possible concerns around unregistered schools and pupils being encouraged towards home education for their schools' benefit rather than their own. Capacity issues have meant that planned visits to check arrangements for electively home educated children have not taken place during the autumn term. It is anticipated that recent appointments will improve this position, but it was too early to see any impact at the point of the inspection.

The experiences and progress of children in care and care leavers: Requires improvement to be good

17. Decisions to look after children are not always timely and not all are underpinned by updated assessments of their circumstances. Care proceedings take too long, and both the Children and Family Court Advisory and Support Service and the district family judge report significant concerns about the timeliness and quality of social workers' evidence. A small number of children experience continued harm as opportunities are missed to safeguard them when risks increase.

18. Most children who come into care are placed in suitable settings. A lack of sufficient local placements means that some matching, particularly for vulnerable adolescents, is resource-led rather than child-led, resulting in some children living in settings a long distance from Southampton.

19. Visits to see children, including a substantial number placed at a long distance from the local authority, largely adhere to their care plan requirements and most children are seen alone. Some children are not seen soon enough following their entry to care. Many children benefit from thoughtful direct work, but not all children living in long-term care arrangements have life-story work carried out with them to help them understand their earlier family history and connections.

20. Some children in care have too many changes of social worker, further compounded by changes to their independent reviewing officer (IRO). This makes it difficult for them to form lasting and trusting relationships. Children can easily access independent visitors and advocates, ensuring that they are well supported, particularly if their families are not involved. Well-established and active groups for children in care and care leavers enable many children to contribute to policy and practice.

21. Most children's reviews are held on time, but the quality of many minutes and care plans are not sufficiently detailed or specific, making children's progress difficult to measure. Children are strongly encouraged to attend and participate in their reviews and can easily access independent advocates. Children who live with their sisters and brothers often do not have separate care plans and their distinct needs are not clearly documented. When IROs challenge on children's behalf, the outcome of their scrutiny is not always visible on case records.

22. Children's permanence plans are considered at their three-month reviews, and a permanence panel has recently started to meet to ratify plans and explore whether all potential options have been considered. The panel is in its infancy and its impact is not yet evident in all cases. The full range of permanence options are usually explored, including special guardianship orders (SGOs), adoption and long-term fostering. This means that most children in care for lengthier periods are in secure long-term arrangements. Children who return home to their parents are well supported through careful preparation and assessment. Suitable legal arrangements, such as supervision orders, are buttressed by active IRO oversight. Placement stability meetings are not arranged for all children when their care arrangements become unstable. This means that opportunities are missed to provide support and guidance to carers who may be struggling to manage challenging behaviours and prevent further moves for children.

23. Assessments of the capacity of parents to care for their children, completed by a specialist assessment team for care proceedings, are well informed and provide a detailed understanding of parents' and children's histories as well as a balanced analysis of risks and their impact on children. Children in care are placed with their parents, or other family members, following careful assessments compliant with placement with parents' regulations and comprehensive connected person's assessments. A wide spectrum of services support parents and children, both in preparing children for reunification, and in continuing work following their return home. Care orders are discharged without undue delay. The quality of SGO assessments vary: stronger assessments are timely, with well-balanced reflection and analysis woven through reports.

24. Children's physical health and dental needs are addressed, although some initial health assessments are not completed quickly enough. Children's emotional and mental health needs are recognised but are not always promptly addressed, primarily because of lengthy waiting times to access child and adolescent mental health services. However, a wide range of other services, including an effective behaviour and resilience team, provide valuable support to carers, helping them to understand and manage children's emotional and behavioural needs.

25. Children in care who go missing and may be at risk of sexual and other forms of exploitation, receive responsive services from knowledgeable staff in the MET team. Diligent multi-agency work often reduces risks of exploitation, exposure to gangs, criminal associations and honour-based violence. Risks are often reduced for children in care who frequently go missing. Most children are offered and engage in timely return home conversations that provide useful intelligence to counteract further risks.

26. Leaders of the virtual school understand the importance of their role as advocates for children in care and work efficiently. Funding for these children is used well to improve their education experiences. Leaders provide helpful training that supports designated teachers in schools to have high expectations of children and receive useful help. Schools are effectively held to account for the impact of their work through regular reviews of children's personal education plans. Consequently, children in care in Southampton attain in line with their peers elsewhere in England.

27. The sufficiency of placements to meet the diverse needs of children in care remains a significant challenge, and the local authority received fewer enquires to foster in 2019 than the previous year. Foster carers are mostly well supported by supervising social workers, although the breadth of training available to carers is not comprehensive enough to provide an understanding of all their responsibilities. While management arrangements across the fostering service have been strengthened, several actions remain from the previous inspection, for example improving how the voice of the child is captured and evidenced, and greater access and choice of training for foster carers. The fostering panel is largely efficient, although children's social workers do not routinely attend, and this limits the information available to the panel concerning the matching of carers to children.

28. 'Adopt South', a new regional adoption agency, provides Southampton's adoption arrangements. Recruitment of adopters meets the needs of children waiting and adoption assessments are of a good standard. Professional and compassionate support is provided by skilled adoption workers, and adopters were overwhelmingly positive about the support they receive throughout their adoption pathway. Adopted children are helped to make sense of their journey through the preparation of good-quality later life letters and life-story books.

29. Personal advisers (PAs) strongly support the needs and well-being of care leavers through purposeful and timely visits, and their views are well reflected in case records. PAs and social workers are in touch with nearly all young people, and in circumstances where young people are hard to engage, case records demonstrate persistent efforts by PAs to reach out to them. Preparation of young people for independent living is effective and well targeted. Most young people can access a range of suitable and safe accommodation. However, the local authority has recently placed some young people in bed and breakfast accommodation. In these circumstances, risk

assessments are compiled, but they are not always detailed or rigorous. Visits by PAs to young people in bed and breakfast accommodation are not always sufficiently frequent, and the PAs are not always mindful of the potential risks arising from residing in these settings.

30. Most pathway plans are completed with the young person, but the format of the plans is not user friendly. The quality of the plans is mixed, but most are of an acceptable standard and some are of a better quality. Plans are regularly reviewed and updated following significant events or changes for the young person. The health needs of care leavers are monitored and addressed by PAs. Health passports have been recently designed for young people but have not yet been implemented. Proactive measures have been pursued by senior leaders to improve the proportions of care leavers in education, training and employment. These have helpfully included securing some apprenticeship schemes with local employers. However, progress has been slow, and numbers are increasing from a low base.

The impact of leaders on social work practice with children and families: Requires improvement to be good

31. Progress in improving services for vulnerable children has been intermittent since the 2014 inspection. Services for children in need of help and protection and for children in care still need improvement to be good. Young people leaving care now receive good support, but too many have been inappropriately placed in bed and breakfast provision. Politicians and senior managers have recently developed a stronger collaboration to ensure that vulnerable children are a corporate priority. Significant additional funding has been provided to fund more social work posts to contend with a large and unexpected increase in referrals that occurred earlier this year. The consequences of this surge in referrals is still being managed through additional temporary peripatetic teams, which are engaging with a significant number of children and families for whom statutory assessments and interventions are delayed. Some social workers in the assessment teams are also still dealing with incomplete work.

32. The director of children's services (DCS) and her management team have worked hard to address the consequences of very high workloads for social workers in the assessment and PACT teams. At the point of the inspection, social workers' caseloads had substantially reduced and were largely manageable. Addressing this challenge has consumed considerable senior management time and diverted their attention from planned improvement work.

33. Senior leaders contend that a significant rise in levels of poverty over a four-year period in more economically deprived wards of the city has been a primary cause of increased referrals through the MASH. However, they have not explained why a reported four-year trend in escalating deprivation

triggered such a marked and relatively sudden increase in referrals at a particular point in that cycle. Leaders and managers also acknowledge that inconsistent decision-making in the MASH was also a significant contributory factor.

34. Senior leaders value external evaluations of their services, and more recently these have featured reviews of the effectiveness of decision-making in the MASH. Performance indicators are regularly and closely evaluated at the children and family scrutiny committee and at other committees and boards. The DCS was line-managed until recently by a chief operations officer, an arrangement that was not compliant with statutory guidance. The chief executive has now assumed direct line management of the DCS, and this is providing the council's most senior manager with a more assured understanding of children's services.

35. Senior managers have a realistic assessment of the standard of practice across the spectrum of services. Their capacity to implement and sustain improvements in core social work practice across the assessment, PACT and children in care teams has been interrupted by addressing a large surge in referrals and additional work that overloaded statutory social work teams.

36. The local authority's self-assessment describes numerous improvement activities, but could be strengthened by a more incisive evaluation of the quality and impact of core frontline social work with children and families. Multiple meetings scrutinise the performance and quality of services for children, including a quarterly improvement group, monthly improvement boards, and weekly performance meetings, alongside extensive quality assurance and auditing work. Performance information provides regular, accurate data reports, which are used well to probe variances and instigate further enquiries. Comparatively far more children than nationally are looked after and are the subjects of child in need plans, and the self-assessment does not explain why there is such a large disparity.

37. The quality of work with children in the assessment and PACT teams is too inconsistent, and risks to children from parental mental ill health, domestic abuse and substance misuse are not always fully understood and responded to with enough urgency. Inspectors alerted senior managers to a small number of children whose safety and well-being remained compromised. Management oversight and supervision is recorded regularly, and this helps in directing social workers to complete important tasks. More needs to be done to help social workers think and plan more thoughtfully and professionally about the aims and objectives of their direct work with children. The introduction and promotion of restorative practice, despite widespread workforce training, is not often understood or manifested in frontline practice with children and families. Reflective group supervision circles are developing, but the learning and messages from these groups are not yet tangibly evident in subsequent case planning and individual supervision records.

38. Caseloads have reduced to more manageable levels for most social workers. Team and service managers routinely use live performance information to control and manage workflows in their teams. Many social workers regularly access a broad range of learning and development activities, and some were able to describe to inspectors how these programmes have subsequently developed their practice skills. An array of shorter learning workshops on important learning themes emanating from audits and serious case review recommendations are routinely provided for frontline workers. Social workers in their assessed and supported year in employment are supported well, and many remain in Southampton.

39. A practice improvement group and themed auditing programmes are well targeted on improving critical areas of practice, including children affected by neglectful parenting. A current priority improvement plan reflects many of the widespread inconsistencies in the quality of social work practice for children seen during the inspection. Senior managers are well sighted on areas of practice that require strengthening. However, the local authority is in the third year of a quality assurance improvement delivery plan, and variable standards in core social work practice across the service remain prevalent. Some recommendations from the 2014 inspection remain pertinent.

40. Despite recent intense workload pressures for social workers, particularly in the assessment and PACT teams, senior leaders have worked effectively to retain a predominantly stable and experienced cohort of frontline social workers. Turnover and vacancy rates are average, and considerably more social workers have started work in Southampton than left over the last year. Despite these favourable conditions, high pockets of sickness in some teams, compounded by internal changes to social workers, have resulted in numerous changes of social workers for many children. These fractured social worker allocations limit the construction of well-established, trusting professional relationships with children. Frontline and middle manager layers are largely permanent, and social workers reported they are well supported by their team managers and that service managers are both visible and available.

41. Senior leaders and politicians have launched a wide range of initiatives for children in care, demonstrating energy and zeal in their corporate parenting roles. The new lead member for children is bringing fresh impetus, scrutiny and insights in his role as chair of the corporate parenting board. Children's participation and feedback is widespread, multi-layered imaginative and influential. However, despite influential and important corporate parenting work, too many children in care are not benefiting from the diligent individual care and attention to their needs that is routinely provided in many birth families.

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