Southend-on-Sea Borough Council

Inspection of children's social care services

Inspection dates: 15 July 2019 to 26 July 2019

Lead inspector: Brenda McInerney
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

Services for children in Southend-on-Sea require improvement to be good, as was the case at the last inspection in 2016. While senior leaders have made significant progress in some areas in improving the quality of practice, despite a challenging local context, there is more work to do. Leaders have concentrated heavily on strengthening the 'front door' multi-agency response to contacts and referrals, planning for children in need and services for vulnerable adolescents, following learning from a joint inspection. These services are now highly effective.

However, progress has been uneven, and some improvements are not yet making enough difference for children. Senior leaders had recognised many of the weaknesses found during the inspection, but action plans are not driving improvements at a sufficient pace. While initial work to protect children at risk of harm is prompt and of a consistently good quality, too many children with longer-term plans are not made safe quickly enough. Progress in improving permanence planning for children with a plan of long-term fostering has been slow. Support and training for foster carers is starting to improve following significant challenges within the service.

Although leaders have increased management capacity, the quality of oversight and decision-making that managers provide is not yet consistently effective. As a result, weaker practice is not always recognised or challenged, and delays in making changes for children are not always addressed decisively.

A well-embedded performance management system has helped to sustain improvements in the timeliness of core social work practice, most of which is well matched to the needs of children. Senior leaders recognise that the quality assurance framework they have recently put in place is not yet providing them with a wholly accurate understanding of the quality of front-line practice or of whether children have better outcomes because of the help and support they receive.

What needs to improve

- Managers' and leaders' oversight, and evaluation, of the quality of frontline practice, and translating this into timely planning for improvements for children within their timeframe.
- The quality of planning for children in need of protection.
- The oversight and challenge from independent chairs of children's child protection conferences and children's care reviews.
- The timeliness and effectiveness of pre-proceedings under the public law outline (PLO) arrangements.

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

1. While many of the services that keep children safe are effective, the inconsistent management oversight and grip on some key child protection processes mean that change for children is not always timely or sustained. Too many families experience repeated assessments. When risks do not reduce for children, ineffective monitoring means that there can be delay in children's cases being brought before the court.

2. Children and their families benefit from a wide range of early help services in Southend which work effectively with families to promote children's welfare and reduce risk. Partners take the lead in completing early help assessments and play an active role in planning and reviewing early help services for families. Families are involved in evaluating the help they receive; they report that things are better following intervention.

3. Initial responses to concerns about children at risk are prompt and thorough, and thresholds applied within the multi-agency safeguarding hub plus (MASH+) are proportionate and consistent. Well-considered initial decisions are made, including out of hours, about the help and protection that children need. Partners make timely and detailed referrals when they are concerned about children. Decisions and discussions about risks to children are well informed by the history of previous interventions and a wide range of partner information, including from health providers and GPs.

4. The practice of undertaking statutory visits by MASH+ social workers to establish the need for an assessment in a small number of cases means that some children and their families are having to tell their stories more than once. In other examples, duty visits delay the start of meaningful work by the allocated social worker. Leaders do not have a clear understanding of the experiences of children and families subject to this practice.

5. The risks to victims and children affected by domestic abuse are well understood. The dedicated multi-agency risk assessment team (MARAT) supports effective information-sharing on high-risk incidents and ensures that safety planning results in children's situations improving. Where risks are less acute, children and families are identified and connected to targeted support, such as groups for parents and children.

6. Assessments are timely, and children and families are connected to targeted help and support during the assessment process. This is making a difference for parents, who are being helped to address mental health or substance misuse difficulties. Children's views inform assessments through sensitive direct work with their social workers. This is supported by a flexible needs-led approach to the number of assessment visits by social workers. There is particularly strong practice in pre-birth assessment and early permanence planning. However, chronologies are not used to understand the patterns of neglect experienced by a high number of children in Southend-on-Sea.

7. The process of automatically re-assessing any family referred to the MASH+ within six months of social care involvement ending is not always proportionate to the presenting risk. Some families are subjected to unnecessary social care intervention when initial enquiries could have better established risks and informed a more appropriate response.

8. The majority of child in need planning is helping to improve children's circumstances. Social workers have time to spend with children, visits are purposeful and capture children's views, and workers build trusting relationships with children and parents. Families are given enough time and support to make and sustain changes in their parenting, an improvement since the previous inspection. Social workers plan carefully for children and families in order to ensure that they continue to receive help after their involvement comes to an end. For a small number of children, there is delay in escalating to

child protection planning where child in need work is not reducing risks quickly enough.

9. A wide range of partners participate in well-chaired and well-recorded strategy meetings, ensuring that child protection enquiries are child-centred and identify the risks to children and result in immediate safety planning. Decisions to progress to initial child protection conferences are proportionate and these meetings are now consistently timely for children and families.

10. Some child protection plans are not of a good quality. In these cases, children experience delays before receiving the level of help and intervention they need. When children are not being made safer, there is a lack of direction by managers, and limited challenge by child protection conference chairs. This means that some children are remaining in neglectful circumstances for too long, exposed to cumulative risk of harm from domestic abuse and parental ill-health and/or substance misuse. In better practice, child protection planning is more effective and helps produce positive change. Skilled social workers are able to forge working relationships with families, even where there have been high levels of resistance.

11. Practice in pre-proceedings under Public Law Outline (PLO) work is inconsistent. Poor tracking by managers and delays in commissioning assessments hamper timely decision-making about applications for court orders. At times, urgent legal planning is being delayed because of a lack of clarity about which meetings and panels make decisions. This means that some children are left in situations of risk for too long. In better managed cases, assessments are timely, and progress is closely monitored by managers. Letters to parents at the start of pre-proceedings work are too long and do not clearly explain the change required from parents to care for their children successfully.

12. Most children with disabilities are well supported by their social workers, who understand their needs well. Social work visits are purposeful and well recorded. However, inconsistent practice means that, for a very small number of children subject to a child protection plans, risks are not identified and responded to soon enough.

13. Children at risk of exploitation experience highly effective help and support from a range of skilled practitioners within the Adolescent Intervention and Prevention Team (AIPT). Children and young people benefit from persistent efforts to engage them. Risk is assessed well, and effective support services contribute to multi-agency planning. In most cases, this significantly reduces the risk of harm, and children's situations improve.

14. When children go missing from home or care, they are consistently offered return home interviews. Although these are not always completed within the required statutory timescales, they are prioritised in line with the level of risk

being presented. However, children's records do not always demonstrate that intelligence from these interviews is being shared with key professionals to inform work to prevent further missing episodes.

15. Referral pathways for homeless 16- and 17-year-olds are under-developed, resulting in an inconsistent level of response. While the number of young people presenting as homeless is small, they do not all have their needs formally assessed. Homeless young people are not always informed of their rights to become accommodated where appropriate and in line with their wishes.

16. Robust systems are in place to safeguard children who are home educated or missing from education. The work of the Fair Access Panel is ensuring that pupils do not change schools unless this in their best interests and there is sufficient support to meet their needs.

17. Arrangements to ensure the suitability of care for privately fostered children are well established. Children's welfare is monitored, and support is provided when required.

18. There is an effective system in place for the management of allegations against adults working with children. Individual risks to children are identified and responded to swiftly.

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

19. Most children live in placements that meet their needs. When care proceedings are issued, they are concluded within recommended timescales, and timely legal permanence is secured for children. The local judiciary and CAFCASS spoke positively about the quality of evidence and care plans put before the court.

20. Wherever possible, children are matched appropriately to carers. Most children receive high-quality care in stable placements. However, when this is not the case, independent reviewing officers are not always effective in recognising and challenging children's experiences. While some children benefit from timely matching with permanent carers, delays for children in achieving permanence through long-term fostering are not being picked up and addressed effectively.

21. The overall quality of care planning is not yet good. While plans are comprehensive, too many actions are too broad and have no date for completion. Social workers' reports to children's reviews are too limited. Records of reviews are frequently missing from or are added very late to children's records. As a result, key decisions for children are not well informed by their current circumstances and delays are not always followed up by their social workers and reviewing officers. There has been little progress in

addressing these weaknesses, which were already identified at the last inspection.

22. Only a small number of children live a long way from Southend-on-Sea and for those that do there is no detriment in the quality of care and support they receive. Children in care are helped to stay in touch with family and friends; planning is sensitive and regularly reviewed to ensure that contact is a positive and fun experience for children.

23. A small number of children have experienced a high number of changes of care placements without there being any learning from disruption meetings or any pause to improve the quality of matching children to the right carers. This means that there is limited planning to reduce the risks of future placements breaking down. Very few children benefit from an up-to-date holistic social work assessment to inform their care planning reviews, even when their care plans or circumstances change.

24. The quality of the fostering service is improving, from a low base, following recent action taken by leaders. Assessments and reports to the fostering panel do not always consider foster carers' abilities to care for two or three children. As a result, decisions to place children in foster placements with other children are not always informed by current knowledge of the carer's capacity. A small number of children experience unplanned moves because, as one of several children in placement, their needs are not being met.

25. Annual reviews of foster carers have not all been completed in time or to required standards. As a result, opportunities are missed to identify how carers will be supported to undertake ongoing training and development appropriate to their experience. Not all foster carers receive regular supervision from their supervising social worker. Inspectors saw a very small number of examples of children's placements ending in an unplanned way due, in part, to a lack of earlier intervention for children and focused support for carers.

26. Children in care and care leavers get good support to keep themselves safe. This includes, where appropriate, the provision of specialist placements to address risks from exploitation. Children at risk from misusing substances get prompt support from the co-located youth drug and alcohol team (YDAT).

27. Assertive action is improving educational outcomes for children in care. The virtual school is effective and works in close partnership with social workers and carers to ensure that each child's educational needs are met and prioritised. This is an area of significant progress since the last inspection. There is challenge as well as support to schools to promote children's success, and personal education plans are of a good quality and include children's views. A specialist worker within the virtual school is helping to reduce school exclusions for children in care.

28. Inspectors saw many examples of children in care not having timely access to mental health and therapeutic support. In some instances, there were unacceptable waiting times of up to 30 weeks from referral to receiving a service. There is no dedicated pathway for children in care to access the locally commissioned mental health service for children. This causes significant problems as children already enter care with a high degree of trauma and attachment difficulties. To address this gap, senior leaders have funded a mental health practitioner who provides valuable interventions to children and their carers. Leaders recognise that they need to do more to improve children's access to therapeutic support and its impact for children and their carers.

29. Children and young people have access to advocates to take forward their concerns and complaints. Senior leaders take these representations seriously and issues are resolved, for example when children wish to change or maintain their care placement. While a small number of children have the benefit of an independent visitor, a much larger number are still waiting for this support.

30. Children's need for life-story work is clearly recognised within their care plans. In practice, however, the arrangements that the local authority has made with a dedicated service for this to be completed can lead to delays for some children whose plan is other than for adoption. Too many young people are being asked to plan for their future beyond care without a clear understanding of their past.

31. There is effective planning for children to return home from care when reunification is in their best interests. Decisions are based on thorough assessments of the needs of the children and carers concerned. This includes effective use and monitoring of planned placements with parents on a care order. After returning home, flexible support, including at evenings and weekends, ensures that children remain appropriately cared for within their families.

32. Practice for children with a plan of adoption and for adoptive parents is an area of excellence. The oversight by the agency decision-maker is thorough and robust. The service is using a virtual reality tool to help prospective adopters to understand typical early childhood experiences of those children being considered for adoption. There has been no disruption to any adoption arrangements in 10 years.

33. Care leavers in Southend benefit from strong relationship-based practice. Services are centred around a drop-in centre from where young people can access a wide range of support. Staying put with foster carers is increasingly available as an option for those care leavers for whom it is relevant. For others, there is a range of good-quality accommodation available with support as needed. Concerted efforts are made to help young people stay and thrive in their education or employment, including going to university or taking up job opportunities provided within the council. While the young people spoken to

were positive about the help they get, they did not all have complete information about their entitlements.

34. Case records for children in care are too variable in quality. Too many records are either incomplete or delayed. This can hamper the ability of a new social worker, auditor or practitioner undertaking life-story work, or even a child accessing their records in later life, to gain a clear overview of the key events in a child's life.

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

35. There is strong cross-party political and corporate support for children's services. At a time of budget pressures, elected members have agreed additional investment in children's services and have protected non-statutory early help services. The lead member, although new in the role, is already providing effective challenge to the senior leadership team. Strategic planning for children's services is aligned well with wider corporate planning, helping to ensure that children's services are given a high priority.

36. An improvement board has driven some service developments since the last inspection. However, some areas for improvement have not yet been sufficiently addressed. The key strategic priorities and plans for improvement are well focused and emphasise the need for a better understanding of children's experiences and of measuring impact rather than just outputs. However, strategic ambition is not always translating into clear action plans at an operational level and at the pace that children deserve.

37. A case model of restorative practice is being embedded, but is too recently introduced to have positively influenced the inconsistencies in quality of practice. Leaders in Southend-on-Sea work closely with high-performing partners in practice from within the social care sector in order to inform their improvement planning.

38. Governance arrangements are effective, and the chairs of all the key boards meet regularly to plan together. Despite working within a challenging local context, senior leaders have been proactive in building a coherent multi-agency strategic framework to guide efforts to improve outcomes for vulnerable children.

39. Partnerships are a strength in Southend-on-Sea. Arrangements for vulnerable groups, such as children at risk from exploitation or domestic abuse, are highly effective. Leaders work collaboratively with CAFCASS and the family courts, and this is helping to secure early permanence for children. Partners have a high degree of trust in the senior leadership team. However, the multi-agency strategic approach to identifying and responding to neglect is underdeveloped,

despite this being a concern for many children in Southend-on-Sea. While planned initiatives around assessments and tools to measure neglect are appropriate, these are not being implemented quickly enough.

40. Progress in corporate parenting since the last inspection has been uneven. Senior leaders recognise that they need to be more ambitious in their expectations of outcomes for children in care and care leavers. Very few children are engaged in the children in care council or care leavers group, so their views are not routinely used to inform the work of the corporate parenting group. The local authority has clear plans to promote these groups and increase children's participation. The corporate parenting group is providing some successful challenge, for instance by improving timeliness of health assessments. However, it has not sufficiently focused on other key areas, such as the impact for children in care of waiting for mental health and well-being services.

41. Senior leaders understand the needs of the wider community and generally commission resources that are making a positive difference for children and their families. These include, for example, programmes for perpetrators of domestic abuse and responses to child exploitation. However, the current sufficiency strategy is not informed by a needs assessment which analyses the range and complexity of the current and future needs of children in care and care leavers. As a result, the strategy narrowly focuses on increasing the numbers of fostering households rather than on increasing residential care and accommodation for care leavers.

42. Leaders have made considerable progress since the last inspection in developing a reliable performance management framework. First-line managers now have the tools to maintain oversight of performance within teams. This is helping to sustain significant improvements in the timeliness of social work visits, assessments and child protection processes. A suite of reports, including a weekly dashboard for the chief executive and lead member, is helping leaders and managers at all levels to accurately track compliance and activity.

43. A recently revised quality assurance framework is having an impact on improving social work practice from the low base seen at the last inspection. It provides the building blocks towards a better understanding of practice and focuses on outcomes for children, rather than just inputs. However, inconsistencies in auditing have meant that senior leaders have an overly optimistic view of the quality of practice. The low number of case audits of child protection planning has made it harder to recognise weak practice in this area.

44. Senior leaders have increased management capacity since the last inspection. This has resulted in more frequent management oversight and supervision. However, the quality and effectiveness of this oversight is too inconsistent and, where drift and delay are evident in children's planning, decisive action is not

always taken by managers at all levels. As leaders have recognised, not all supervision is yet providing a reflective space. They are currently implementing a new model of 'restorative' supervision in order to secure improvement.

45. The social care workforce in Southend-on-Sea is stable and experienced, with lower than average numbers of temporary staff. While caseloads for social workers are mostly manageable, for a small number of social workers caseload complexity is not always commensurate with their level of experience.

46. Social workers told inspectors that they enjoy working in Southend-on-Sea, that they work in supportive teams and they feel valued by managers and senior leaders. Social workers see themselves as very much part of the community of Southend-on-Sea and are committed and motivated to get the best outcomes for children.

The Office for Standards in Education, Children's Services and Skills (Ofsted) regulates and inspects to achieve excellence in the care of children and young people, and in education and skills for learners of all ages. It regulates and inspects childcare and children's social care and inspects the Children and Family Court Advisory and Support Service (Cafcass), schools, colleges, initial teacher training, further education and skills, adult and community learning, and education and training in prisons and other secure establishments. It assesses council children's services, and inspects services for children looked after, safeguarding and child protection.

If you would like a copy of this document in a different format, such as large print or Braille, please telephone 0300 123 1231, or email enquiries@ofsted.gov.uk.

This publication is available at www.gov.uk/government/organisations/ofsted.

Interested in our work? You can subscribe to our monthly newsletter for more information and updates: http://eepurl.com/iTrDn.

Piccadilly Gate
Store Street
Manchester
M1 2WD

T: 0300 123 1231
Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
W:www.gov.uk/ofsted