

London Borough of Southwark

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 Board¹

Inspection date: 6 March 2017 – 30 March 2017

Report published: 13 June 2017

Children's services in Southwark are good	
Children who need help and protection	Good
Children looked after and achieving permanence	Requires improvement
2.1 Adoption performance	Outstanding
2.2 Experiences and progress of care leavers	Requires improvement
Leadership, management and governance	Good

¹ Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspections Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

Executive summary

Children's services in Southwark are good overall. Leaders and managers understand the strengths and areas for development of their service well. Southwark attracts experienced, high-quality social workers who are keen to work in small units that employ systemic methods, under the 'social work matters' initiative. This model, launched in 2014, is well established. The model is well resourced and features clinical and group supervision alongside manageable caseloads. This promotes influential and effective direct work with children and families. The model is enabling a flourishing social work culture in the local authority, equipping social workers to address complex local concerns in this highly diverse community, including serious youth violence, gangs and female genital mutilation.

The local authority continually strives to improve, developing innovative services which are informed by children's participation and involvement. This shapes the design of adaptable and flexible services and improves outcomes for children. High-quality management oversight is not yet consistently good across all parts of the service. The local authority has recognised this shortfall and is working quickly to ensure that all social workers receive good-quality management oversight, support and challenge.

The majority of children and families in Southwark are helped through carefully designed services. The multi-agency safeguarding hub (MASH), formed of 20 agencies, is effective in responding to cases when children are at risk of harm, although managers' decisions on referrals are not consistently completed within the required 24-hour period. There are also missed opportunities to involve all relevant partners in child protection strategy discussions.

Younger children who have emerging and additional needs are helped through an extensive range of services clustered around children's centres. Targeted early help for some younger children who have more substantial difficulties is helpfully focused on their educational needs, but would be further strengthened by a more holistic response to a wider range of difficulties affecting their lives at home. However, there are strong early help services for older children, helping families and children to improve their lives and preventing the need for subsequent statutory social work involvement.

Assessments of children's and families' circumstances identify the major difficulties facing children and their families. This results in focused child in need or child protection plans for most children, which contribute to reducing risk. Southwark and its partners have particular strengths in identifying and protecting young women at risk of female genital mutilation, honour-based violence, bullying or sexual exploitation through gang associations. Women who have experienced earlier multiple removals of their children through care proceedings are helped to change radically the subsequent direction of their lives through a highly successful, award-winning project called 'Pause'.

The local authority engages constructively with families with children for whom there are serious safeguarding concerns in the pre-care proceedings stages of intervention and prevents the majority from subsequently entering care. Social workers produce timely and well-constructed evidence when care proceedings are necessary.

The local authority has developed strong, creative and adaptable multi-agency partnership responses to address child sexual exploitation and other risks to adolescents, such as knife crime. Children who go missing from home or care are closely tracked, although return home interviews are not regularly completed and, when they are, the information obtained to help to prevent further missing episodes is not always of good quality.

Senior managers are aware that too many children in care, especially older children, have too many placement breakdowns that are, in many cases, the result of poorly planned and matched placements. Early adoption permanence planning is strong, but there are delays in achieving permanence for too many children in long-term fostering arrangements.

The quality of management oversight for children in care is not sufficiently challenging to improve outcomes for all children. This is further inhibited by many children in care having too many changes of social worker, preventing them from establishing strong relationships built on professional trust.

Many care leavers live in safe, suitable housing and achieve good outcomes in their education, employment and training. Some young people are not fully informed about the support and entitlements that would help them, even if they are doing well at college or university.

The local authority has a well-established culture of identifying children at the earliest stage of their difficulties, who might go on to be adopted, and carefully tracks and promotes adoption or other forms of legal permanence as soon as possible. Adopters highly appreciate the assessment, training and support that they receive from knowledgeable and dedicated social workers.

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The local authority

Information about this local authority area²

Previous Ofsted inspections

- The local authority operates one children's home, which was judged to be good in its most recent Ofsted inspection. This is a short-breaks service, which is registered as a five-bedded children's home.
- The previous inspection of the local authority's safeguarding arrangements was in May 2012. The local authority was judged to be good.
- The previous inspection of the local authority's services for children looked after was in May 2012. The local authority was judged to be good.

Local leadership

- The strategic director of children's services (DCS) has been in post since October 2014.
- The DCS is also responsible for adults' social care services.
- The chief executive has been in post since July 2012.
- The chair of the LSCB has been in post since May 2013.
- The local authority uses the systemic and signs of safety models of social work.

Children living in this area

- Approximately 62,000 children and young people under the age of 18 years live in Southwark. This is 20.3% of the total population in the area.
- Approximately 28.2% of the local authority's children aged under 16 years are living in low-income families.
- The proportion of children entitled to free school meals:
 - in primary schools is 19% (the national average is 15%)
 - in secondary schools is 29% (the national average is 13%).
- Children and young people from minority ethnic groups account for 65% 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 Black African and Black Caribbean.
- The proportion of children and young people who speak English as an additional language:

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.

- in primary schools is 46% (the national average is 20%)
- in secondary schools is 36% (the national average is 16%).

Child protection in this area

- At 28 February 2017, 2,694 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 3,339 at 31 March 2016.
- At 28 February 2017, 327 children and young people were the subject of a child protection plan (a rate of 52 per 10,000 children). This is an increase from 284 (45 per 10,000 children) at 31 March 2016.
- At 28 February 2017, 35 children lived in a privately arranged fostering placement. This is an increase from 21 at 31 March 2015.
- In the two years before inspection, two serious incident notifications were submitted to Ofsted, and one serious case review (SCR) was completed.
- There was one SCR ongoing at the time of the inspection.

Children looked after in this area

- At 28 February 2017, 510 children were being looked after by the local authority (a rate of 81 per 10,000 children). This is an increase from 475 (75 per 10,000 children) at 31 March 2016.

Of this number:

- 368 (or 72%) live outside of the local authority area
 - 57 live in residential children's homes, all of whom live out of the authority area
 - none lives in residential special schools³
 - 390 live with foster families, of whom 68% live out of the authority area
 - five live with parents, of whom 40% live out of the authority area
 - 32 children are unaccompanied asylum-seeking children.
- In the last 12 months:
 - there have been 18 adoptions
 - 18 children became subject of special guardianship orders (SGOs)
 - 242 children ceased to be looked after, of whom 3% subsequently returned to be looked after
 - 29 young people ceased to be looked after and moved on to independent living

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

- no young people ceased to be looked after and are now living in houses in multiple occupation.

Recommendations

1. Ensure that prompt decisions are made to safeguard children affected by long-term, cumulative neglect, so that they are not left in adverse home circumstances for long periods.
2. Work with partner agencies to ensure that referrals contain sufficient information and that parental consent has been obtained if necessary, so that management decisions on the required action are timely and families receive help quickly.
3. Ensure that strategy discussions and strategy meetings involve all relevant agencies so that multi-agency information informs assessment of risks.
4. Ensure that return home interviews with children missing from home and care are completed consistently and effectively so that the intelligence gained reduces the recurrence of further missing episodes.
5. Strengthen management oversight of social workers in the children looked after and care leavers' services.
6. Ensure that the sufficiency strategy, supported by effective commissioning, provides a better supply of high-quality placements for children looked after, particularly for adolescents who display challenging behaviours.
7. Ensure that children's care plans are effectively and regularly reviewed to confirm whether their needs are being met through their placements, and establish alternative plans where necessary.
8. Ensure that children looked after who live outside of the local authority area are not disadvantaged through slower access to essential services, particularly child and adolescent mental health services, education support and regular health assessments.
9. Ensure that children looked after are supported to build strong and enduring attachments to their carers through more timely permanence decisions for long-term foster family arrangements. Ensure timely life story work, which is kept up to date.
10. Ensure that all social workers and personal advisers working with young people leaving care have a clear knowledge of their current circumstances. This aim should be supported through consistently effective pathway planning, to ensure that young people understand and receive all their entitlements and that their identified needs are met.

11. Ensure that children are aware of how to complain about services provided to them and that more advocacy support is provided for children on child protection plans and for those who are looked after. Ensure good access to independent visitors for children looked after.

Summary for children and young people

- Most services for children and families in Southwark are good, and adoption services are outstanding. Managers and local politicians are very determined to continue to improve those services that are not yet good, and they have effective plans to do this.
- Most children and families receive good early help, and, when they need protecting, responses are quick. However, some children who have been neglected by their families have had to wait too long to receive help.
- Social workers each work hard with a small number of families to make sure that children and families get the right help at the right time. Most social workers have time to spend with children to get to know them well.
- Southwark is very good at helping young people who face particular difficulties, such as the risk of female genital mutilation, honour-based violence and involvement with gangs and knife crime. Southwark also does some important work with women who have had their children removed from them to avoid the same thing happening again.
- Managers listen to the views of children carefully. For example, young people have helped the local authority to develop better accommodation for care leavers.
- Many young people leaving care are doing well in work, training or further education, but some young people do not know their rights and entitlements as care leavers.
- Some young people who are looked after by Southwark are moved around too much from one placement to another. Managers need to make sure that the right placements are chosen first time around, so that there is no need for them to move again.
- Social workers in Southwark work hard to ensure that there is no delay for children who may be able to be adopted. Children from a wide variety of backgrounds and of different ages are adopted. When they have been adopted, their parents receive good support from the local authority when they need it.

The experiences and progress of children who need help and protection

Good

Summary

Safeguarding concerns are recognised quickly as they are referred promptly for assessment and action. A large range of partners are co-located in the MASH, which promotes good communication, information sharing and joint working. The majority of contacts are rapidly screened, although not all management decisions are timely. This is because the quality of information provided by referring agencies is not consistently helpful, and parental consent is not always sought in advance, when required. This means that for some children there is some delay in being seen and assessed.

Children and families have access to a good range of targeted early help services, some of which are excellent. Improvements are being made to ensure that all children receive early help in a timely manner, with evidence that an implementation programme is beginning to yield results to achieve this.

Children at risk of significant harm are promptly identified and protected. Thresholds are well understood by staff across children’s social care. Child protection strategy meetings and enquiries are timely and take decisive actions to protect children. In most cases, only the police and children’s social care are involved in strategy meetings. As a consequence, not all available information is being considered at the earliest opportunity.

The majority of assessments feature a clear focus on children and are informed by their experiences. They inform plans characterised by timeliness and clear actions. Most children benefit from regular and effective reviews of their plans, resulting in purposeful progress that reduces risks to them. Direct work with children is well established in Southwark, resulting in high-quality engagement, which enables children to describe their experiences and concerns powerfully. A high proportion of assessments result in no further social care involvement. However, many are stepped down appropriately to a broad range of early help services. This is not consistent across the whole service. In a small minority, long-term cumulative neglect is not always addressed quickly enough.

Arrangements for tracking missing children are effective. Improved responses to children who go missing from home are acknowledged by the local authority as an area requiring further attention.

Work with children at risk of child sexual exploitation is effective, reducing levels of risk for many children. Engagement with young women and girls at risk of exposure to female genital mutilation is very strong, with high numbers of notifications and effective work, including the use of court orders, which reduces risks.

Inspection findings

12. All new contacts concerning children are promptly screened through the MASH. Safeguarding concerns are promptly recognised and passed on quickly for assessment and action. Twenty partners are co-located in the MASH, which has improved communication and joint working. Recent changes have resulted in a consistent core MASH team membership, ensuring good information sharing and effective communication about children and their families. Thresholds are well understood and applied within the MASH and across children's social care. Parental consent, if appropriate, is routinely considered within the MASH and clearly recorded. Screening and triaging of domestic abuse referrals by the police, who are co-located in the MASH, and children's social care are rigorous.
13. In cases considered within the MASH where safeguarding concerns are not readily apparent, many decisions are not completed within the 24-hour target. Timeliness on this aspect has deteriorated in recent months. Regular performance information and a sophisticated live dashboard in the MASH are not being utilised effectively by managers and staff to improve performance and timeliness. Many delays are caused by referrals lacking sufficient information and parental consent. These are most likely for children identified as requiring a child in need assessment. This means that some children who require an assessment of need are not seen soon enough.
14. Out-of-hours arrangements are effective. Interventions are timely and proportionate, and followed up by prompt liaison with daytime staff. Communication and handover are well managed, resulting in continuity for children and families.
15. Work with children at risk of child sexual exploitation is effective, resulting in risks reducing for many children exposed to this danger. Adaptive and creative multi-agency partnerships provide responsive and purposeful approaches to emerging sexual exploitation and other adolescent risks, including knife crime, gangs and honour-based violence.
16. Effective arrangements ensure a robust strategic and operational approach to the identification of child sexual exploitation, prevention, support and disruption of perpetrators. Intelligence is shared well through a strategic multi-agency child sexual exploitation meeting (MASE), operational meetings and a problem profile group. An 'adolescent at risk' meeting is being piloted, which considers multiple risks confronting young people. The child sexual exploitation assessment tool is used well for initial risk assessments, but is used too infrequently to review continuing risks. Constructive joint working has led to informed service developments, such as the youth offending service's gangs team and a child sexual exploitation police team. These initiatives have improved shared intelligence and understanding of risks through an operational child sexual exploitation group. Social workers are kept

up to date on new risks and vulnerabilities about individual children, as well as on specific locations of concern, which assists their preventative work.

17. Work addressing female genital mutilation is particularly strong, with high numbers of notifications and subsequent effective work to reduce risks, including frequent use of court orders. Sensitive community engagement with at-risk communities is evident. Social workers address cultural sensitivities carefully, while remaining risk focused. Children are at the centre of decision-making and child protection plans. Similarly, honour-based violence work is also risk focused and culturally sensitive, with purposeful, child-focused social work. Examples of high-quality direct work with young people facing risks from gangs were seen by inspectors, enabling the young people to powerfully describe their experiences and producing effective interventions to lower risks.
18. Some children do not receive local authority early help in a timely way. Improvements are being made, and an implementation programme is beginning to yield demonstrable improvements. A reorganisation of children's centres is showing early signs of more efficient multi-agency practice and coordination of services. Better-informed targeting of vulnerable groups is providing the right children and families with help. Early help services have developed a more cohesive alignment with children's social care, for example revising their processes and templates to incorporate the same approach to assessments. Services are more needs led and consistent across the borough, utilising both one-to-one and group work to support families. Improved outcomes for children and families are demonstrated through constructive feedback and measures that clearly show how problems and difficulties have substantially reduced.
19. The 'Pause' initiative is an innovative model, demonstrating a positive impact through preventing subsequent care proceedings for women who have experienced repeated removals of their children. The relationship, strength and community-based approach to working with these women are highly valued, resulting in there being no further care proceedings for the women in the 18 months since its inception. No further pregnancies occurred in the last year, alongside improvements in the women's development of positive identities, self-esteem, relationships and enhanced well-being. Contact with their children in care improved, in terms of both reliability and quality.
20. Support provided in four early help locality teams is predominantly school orientated, particularly focused on improving children's school attendance. Some interventions are too parent focused, and children are not always seen sufficiently soon. Delays are apparent in engaging some referred families. Management oversight is not ensuring that children's outcomes are improved. The common assessment framework is underdeveloped and is used by most partner agencies as a referral form rather than as an assessment of children's needs. This leads to some children who have lower levels of additional needs experiencing delays in receiving early help.

21. Children at risk of significant harm are promptly identified and protected. Thresholds are clearly understood and applied by children's social care staff. Child protection strategy meetings and enquiries are timely and result in decisive action to protect children. In most cases, only the police and children's social care are involved in strategy meetings, which results in not all information being considered at the earliest opportunity. Given the number of partners present in the MASH, this is a missed opportunity.
22. Most assessments are completed to a high standard, underpinned by a systemic model of social work that is well established. Assessments are timely and clear, and have a clear focus on children, informed by their experiences. A high proportion result in no further action, but step down to early help services is measured, and appropriate referrals are made to a wide range of agencies. Children's cultural backgrounds and identities are at the forefront of some assessments and interventions, but the impact of ethnicity, inequality and environment on some children is not fully understood. There are limited pockets of the service where assessments are not of a consistently high standard.
23. Most plans are timely and ambitious and have clear, accountable actions. However, this is not consistently the case across the service. The local authority is aware that some practice is not of the standard required, and assertive action has been taken by managers to address performance issues. Social workers effectively engage with family members, addressing presenting and wider needs, and endeavour to involve fathers and male partners, resulting in improved interventions. Child-focused social work results in positive outcomes for the majority of children and families. Long-term, cumulative neglect of some children is not always addressed decisively or soon enough.
24. Plans clearly specify what parents, children and young people need to do to achieve improvements, but some plans could more clearly articulate the outcomes sought by the provision of services. All social workers value weekly systemic group supervision, supported by advanced and clinical practitioners, enabling regular opportunities to share perspectives, analyse, reflect and hypothesise. Reflective and evaluative management supervision in most teams, supported by regular group supervision, results in better decision-making and outcomes for children.
25. Most children benefit from regular and effective reviews of their plans, resulting in purposeful progress and reduced risks. Child protection chairs are confident and escalate issues as necessary, quickly resolving concerns within the children's service and with other agencies. Child in need and core group meetings are also held regularly. However, too few children benefit from the support of an advocate.

26. Children who have disabilities are provided with a good service, co-located with health services for children who have additional needs. Thresholds are applied effectively and, where necessary, safeguarding concerns are escalated appropriately, including subsequent use of the Public Law Outline (PLO). Child protection concerns are swiftly recognised, and involved agencies are appropriately challenged. The completion of assessments and plan objectives for some children is not sufficiently timely. In some cases seen by inspectors, transitions to adult services' provision were characterised by drift in timescales and a lack of management oversight.
27. A range of well-designed services is available to both parents and children. Social workers and their managers are highly aware of the combined dangers for children of domestic abuse, parental mental ill health and substance misuse. Effective services work collectively with families, and individually with parents and children, reducing the risk of harm to children who live in families in which these conditions prevail. The local authority has a comprehensive understanding of the profile of domestic violence, substance misuse and parental ill health. Child in need and child protection plans carefully evaluate the impact of service provision for children and families affected by this trio of difficulties. Multi-agency risk assessment conferences and multi-agency public protection arrangements are both effective.
28. An edge of care service, the 'specialist family focus' team, has improved the outcomes for 130 families with children aged over 11 years. Families benefit from intensive, creative, multi-disciplinary, evidence- and research-based practice grounded in a systemic practice model. The 'keeping families together' team provides a dynamic, strength- and relationship-based 'team around the child' approach, offering intensive family support and achieving positive outcomes for most families.
29. Services for children who go missing from home are acknowledged by the local authority as an area requiring improved practice. Arrangements for tracking missing children are rigorous, through regular monitoring and liaison, with appropriate actions pursued by involved agencies. However, return home interviews are not being consistently completed, and their content does not helpfully inform subsequent work to reduce the risk of further missing episodes.
30. The local authority holds clear and accurate information on children who are missing education and those who are electively home educated. Most children missing education are successfully tracked and identified. Staff undertake checks with all relevant agencies to establish their whereabouts, including housing, local authority council tax records, UK Visas and Immigration and children's social care. Staff regularly see children, ensuring that they have a good overview of their welfare.

31. Clear and well-established joint pathways between housing and social care are in place, ensuring that young people are well supported when they present as homeless. Joint assessments address presenting and underlying issues. Once a young person's immediate needs are considered, interventions, including family therapy or mediation, follow. Unaccompanied asylum seekers also benefit from a well-defined service pathway when they present for support in Southwark.
32. Private fostering arrangements are highly effective. Successful awareness raising has resulted in a significant increase in notifications. Private fostering assessments are timely and completed to a high standard. The use of a specific template ensures that relevant information is gathered. This includes a detailed account of the child's history and direct work ensuring that children's views are taken into account. Parallel with this work, an assessment of the carer is undertaken, including relevant checks and consents. Relevant and purposeful actions are pursued to support children in their placements.
33. The designated officer function has recently been enhanced and is effective. Well-attended strategy meetings provide clear, specific actions. Partnership arrangements are effective, and there are clear reporting arrangements. However, the designated officer does not measure the timeliness of investigations, which is a shortcoming.

<p>The experiences and progress of children looked after and achieving permanence</p>	<p>Requires improvement</p>
<p>Summary</p> <p>The quality of work is too variable for children looked after, and the majority of practice requires improvement. While outcomes for most children looked after are good, they are less positive for a significant minority of children. A small number of children have to wait too long to become looked after. Many experience delays in the starting or updating of their life story work, and some children who are in long-term foster placements have to wait too long to achieve permanence.</p> <p>Overall, there is poor oversight of cases for children looked after by managers and independent reviewing officers (IROs). Delays in delivering children’s care plans and, in a small number of cases, assurance regarding the safeguarding of children, are not being addressed effectively.</p> <p>Too many children have experienced numerous moves and placement breakdowns. There is a lack of sufficient placements for adolescents who have challenging behaviours, and the local authority has been too slow to address this.</p> <p>The local authority has successfully improved timeliness for cases in the PLO, and those issued before the courts. Most children and families subject to the PLO are now effectively supported to reduce risks, allowing children to remain with their families.</p> <p>The virtual school effectively supports and challenges the quality of provision of children’s education for those who are looked after. Children’s attainment is above that of comparators, but the attainment gap between children looked after and their peers remains wide.</p> <p>Younger children benefit from early consideration of permanence, which enables them to live in permanent homes within reasonable timescales. Experienced, well-trained social workers effectively support and prepare children for adoption. Prospective adopters are rigorously assessed and receive high-quality training and post-adoption support. As a result, children thrive in their adoptive homes.</p> <p>The support that care leavers receive is too inconsistent, and managers are not effectively addressing this. While many young people receive the support that they need to make progress in some aspects of their lives, the support and progress that they make is not consistent across all areas. Staff do not know the current needs and circumstances of a significant minority of young people and, as a result, are not in a position to offer the support that these young people need.</p>	

Inspection findings

34. Children become looked after when this is the most appropriate way to meet their needs. A relatively high number of children have become looked after urgently after critical incidents, despite several of them being in the PLO process or otherwise known to the local authority. In these cases, the known risks had escalated to a degree that the children were experiencing situations in which there was high and immediate risk of harm. In a small number of these cases, earlier action may have prevented further adverse impacts for children.
35. For children who return to their families as part of a planned move, risks are assessed and, for most children, effective transition plans are in place. These provide a clear framework to support children and their families both prior to and following return home. For some young people who choose to return home immediately, there are delays in putting effective support plans in place.
36. Following a review of the use of the PLO, a strengthened approach to achieving permanence for children is now in place. A variety of measures, including an effective permanency taskforce meeting, are being used to maintain a strong overview of children subject to the PLO and children with a plan for adoption. As a result, the duration of care proceedings is continuing to reduce for children.
37. Legal planning meetings, support, interventions and relevant assessments are all used effectively to reach clear decisions for families during the PLO. In the majority of cases, actions are followed through in a timely way, and risks are reduced, thereby avoiding the need to progress to care proceedings.
38. The majority of assessments and court statements contain appropriate explorations of histories and risks, and analyse issues well to reach relevant conclusions. They include the views of parents, including fathers, and most provide a good overview of children's needs. However, children's personalities and lived experiences are not always clearly described, particularly those of younger children.
39. Too many children looked after have experienced multiple changes of social workers. Despite almost all children looked after receiving regular visits from social workers, these are not always purposeful, and many children have not been able to establish a strong rapport with their social worker. When children are able to build relationships with their social worker, the quality of direct work is often very child centred, and there is evidence of children's wishes influencing their plans.
40. Advocacy is not being used well for children looked after. Only 11 children were supported by an advocate at their review meetings in 2015–16. The local authority does not know how many children are currently being supported by

the independent visitors' scheme, or how many children are waiting. Despite concerted efforts by the complaints team to advertise the process, children told inspectors that they do not know how to make a complaint.

41. There is a variable response to issues of bullying affecting children. For example, one child who was experiencing bullying was provided with support immediately. For another child, concerns of bullying were not adequately addressed by the professional network or included within the child's care plan.
42. In most cases seen, the risk of child sexual exploitation to children looked after has reduced as a result of intervention and support. This has included appropriate use of secure accommodation, 'keep safe' work and support from sexual health specialists. For children who go missing from care, the quality and timeliness of return home interviews and the quality of planning through regular strategy meetings are not consistently strong or reducing risks. Children who are misusing drugs or alcohol, or who are offending within the community, are offered an appropriate multi-agency response to help them to understand and to reduce the risks associated with their behaviours.
43. Children's physical, emotional and mental health needs are considered, and appropriate services are put in place to meet identified need. These include effective support and intervention from 'CareLink', the well-regarded local child and adolescent mental health service (CAMHS) for children looked after. However, children's physical health needs are not always assessed quickly enough, and the quality of health assessments is not consistently strong.
44. The virtual school maintains a sound oversight of children's progress and attainment, particularly of those who are at risk of under-achievement and those who have poor school attendance. Managers of the virtual school understand well the strengths and areas for improvement of the service and are taking effective action to tackle these. Overall, most children looked after attend a good school regularly, receive good support and make positive progress.
45. Children benefit from additional support provided by new posts in the virtual school, funded by the pupil premium grant. This is leading to improvements for children looked after, for example, in the attainment of those at key stage 4. Education advisers in the virtual school provide good challenge to schools when they do not evidence sufficiently the progress that children are making. They act as effective advocates for children, leading to more timely assessments of their educational needs. They also liaise effectively with professionals, including those outside of the local authority area, so that children are placed in settings that best meets their needs.
46. Children looked after achieve well at key stage 2 and key stage 4 and do better than those in similar areas. However, the attainment gap between children looked after and their peers remains wide. As a result of good

support when young people complete Year 11, the vast majority move into and stay in education, training and employment.

47. Increasingly, children have an up-to-date personal education plan (PEP). However, the quality of PEPs varies too much, and the virtual school is working hard with social workers and schools to continuously improve the quality of PEPs.
48. Diversity is considered well for the majority of children looked after. This includes careful consideration during matching for placements, including ways in which children's needs will be met when a full cultural placement match is not possible.
49. Children looked after are encouraged to engage in positive leisure activities. Social workers and carers are supported to prioritise social, educational and recreational activities for children. However, not all foster carers are aware of their delegated authority to sanction activities for children in their care.
50. The local authority has limited success at placing brothers and sisters together, and many siblings live separately due to lack of placement choice. 'Together or apart' assessments are not consistently timely or of sufficient quality to fully inform children's plans. The large majority of children looked after benefit from carefully considered contact with their families. This ranges from letter box and supervised contact, through to child-directed, flexible contact for older children and young people.
51. Too many children experience numerous changes of placement that are not in accordance with their care plans. While the majority of children are matched appropriately according to their needs, there are also some children who are placed with carers or in residential units that do not meet their needs or adequately safeguard them. Placement stability for children, both long term and short term, is declining.
52. The majority of children's plans and reviews do not sufficiently consider children's personalities, and many fail to identify children's capacity to make and sustain friendships. Some plans do not adequately address issues such as health needs or the impact of a disability for the child. The majority do consider children's basic needs and leisure time preferences. However, there is not sufficiently strong oversight or challenge by managers and IROs when plans for children are not progressed quickly enough. Decision-making and the rationale for decisions are not always clear in children's case records. This means that children seeking to understand their care histories later in life would not be able to fully comprehend their care journeys. Current performance regarding the timeliness of reviews is not strong and is not being addressed with sufficient urgency.

53. The learning and health needs of children who are looked after outside the local authority area are not always sufficiently considered when their placements change. This means that, for many of the large number of children living in other local authority areas, education and health services are secured only after they have moved into their new placements. Children living at a distance are also more likely than others to experience delays in having their care plans reviewed or their health needs assessed.
54. There is not a sufficient range of high-quality placement options available for adolescents, particularly those who present challenging behaviours to their carers. This lack of sufficiency leads to a significant number of placements that repeatedly break down for these young people. The progress towards meeting this gap, which was identified in 2014, has been too slow. There is a suitable range of placement options for children under 10 years of age.
55. Actions taken to recruit foster carers have had very limited impact. In 2016–17, there were 195 enquiries, but these led to only eight new carers being approved. This is despite actively seeking to recruit through regular drop-in and information sessions, and existing foster carers being offered an introduction bonus for any future carers. There are currently eight foster carers undergoing assessments and four waiting for assessments to commence.
56. The quality of decision-making when placing children is further hampered by the variable quality of referrals for placements. There are too many referrals that do not provide sufficient overview of children’s personalities or of their range of needs and issues, to support effective matching decisions.
57. There is a wide range of training offered to foster carers that is highly valued by them. This includes recent training on a more therapeutic approach to caring for children. Oversight of foster carers’ ongoing suitability requires improvement. Record-keeping is poor, and there is a lack of rigour in addressing Disclosure and Barring Service checks and ensuring that foster carers’ training is current.
58. Early plans are being made, especially for younger children, to achieve permanence through an appropriate range of permanency options, including SGOs, connected persons’ placements and adoption. Potential connected persons’ carers and special guardians are assessed thoroughly for their suitability. Special guardians, and the children living with them, are effectively supported when needs arise through direct work with social workers and therapeutic input by CareLink.
59. Social workers, Children and Family Court Advisory and Support Service (Cafcass) guardians and IROs liaise effectively regarding children’s plans for permanence through legal orders. However, most children wait too long to achieve permanence when they are in long-term foster placements. This

means that children may be prevented from building strong, enduring relationships with their carers until firm agreements are reached. This is further hampered when life story work is delayed or in need of updating. Some life story work is excellent and has helped children to explore difficult issues with their carers.

60. 'Speakerbox', the Children in Care Council, has an open membership policy to engage a wide range of children looked after. 'Speakerbox' has achieved a great deal over the past year, including developing training materials to help professionals to understand how important it is that they carefully consider contact between brothers and sisters for children who are looked after.

<p>The graded judgement for adoption performance is that it is outstanding</p>

61. Early consideration of permanence for children is an embedded approach throughout the social work teams in Southwark, and adoption is considered for all children. Children and adopters receive high-quality support from a stable, experienced and well-trained workforce, resulting in children benefiting from a permanent home.
62. Adoption is identified promptly as a potential permanency arrangement. Permanency consultations occur quickly between the adoption team and safeguarding and assessment teams, resulting in a thorough and early understanding of children's needs by the receiving permanency team. When adoption is the agreed plan for the child, the allocated social worker remains with the child through to the stage when an adoption order is made. This attention to continuity means that children develop good, trusting relationships with their social workers.
63. Child permanence reports are of high quality, clearly demonstrating the needs and characters of children. The reports are regularly updated, providing prospective adopters with a contemporary picture of children, in addition to their background histories. Social workers know their children well, and sensitively and accurately describe children's profiles.
64. Life story work is of high quality. Comprehensive and sensitive descriptions of the reasons for children entering care, histories of their birth families and their cultural identities through pictures and photographs provide helpful illustrations. The books also include details of foster families and children's new families. Some adoptive parents spoke of how they regularly refer to the books with their children to help them to understand their pasts. Later life letters are clear, accurate and sensitively written.
65. Careful management oversight of children's progress towards adoptive or other permanent placements is achieved through a range of effective processes. These include a tracker, efficient caseload management and

regular, reflective supervision, resulting in consistently high standards of casework. All options to find the right families for children are pursued, including the South London consortium, Link Maker, the adoption register and national advertising. Close working relationships in the adoption team mean that, when potential adopters are either being assessed or have recently successfully completed their assessments, potential matches for children are speedily identified. Family-finding processes effectively match children, and anonymised child profiles circulated during care proceedings ensure early exploration of opportunities to find permanent families for children.

66. Arrangements to monitor the progress of children who are subject to an adoption plan are strong, with rigorous senior management tracking of timeliness through permanency taskforce meetings. The average timescales between children entering care and moving into adoptive placements, and between placement orders and matching, are improving. When there were delays, inspectors saw justifiable reasons in each case, ensuring the right outcomes for children. Fourteen of the 20 matches reviewed by the panel in the year preceding the inspection had been within 91 days. At the time of the inspection, there were eight children waiting for adoption. Two of these were brothers linked to adopters, with a panel date imminent. Active and persistent family finding was in progress for the other children, including detailed 'together or apart' assessments.
67. Foster to adopt is well established in Southwark, reflected through 10 placements. A clear understanding of early permanence is demonstrated through two recent adoptions of relinquished babies, following swift referrals from the pre-birth team to the adoption team. A skilled and experienced social worker uses regular recruitment drop-ins as an opportunity to explain this option to all prospective adopters.
68. Adopter preparation is excellent. Adopters described a necessarily challenging process, resulting in their feeling well prepared for becoming adoptive parents. Preparation for adoption training was highly regarded by a group of adopters spoken to by an inspector. Southwark is part of the South London consortium, which enables adopters to readily access training courses. One adopter spoke of how well supported she felt through her social worker attending a course with her.
69. Prospective adopter reports are analytical, demonstrating a thorough exploration of relevant issues. Hypotheses are tested through group supervision, and effective management oversight results in high-quality and timely assessments. Checks and references are completed and clearly documented. Adopters from a wide range of backgrounds are approved, reflecting the diverse ethnic communities in Southwark. This includes single carers and same sex couples.

70. When a child requires an assessment and possible therapeutic support prior to adoption, clinical psychologists, the medical officer and the social worker meet with prospective adopters to ensure that they have a clear understanding of the current and potential future needs of the child. Adopters told inspectors that this means that they are fully aware of the complex needs of their children. Adoption support plans are clear and detailed in identifying how future needs will be met. All adopters spoken to were clear about how to access support in the future.
71. Robust quality assurance processes ensure that panel reports are of a consistently high standard. The recently merged adoption and fostering panel benefits from an experienced, knowledgeable chair, and panel membership is suitably diverse. Minutes demonstrate quorate meetings, ensuring effective oversight of adoption decisions. The agency decision-maker is suitably qualified and experienced, and decisions are made promptly. Adopters described positive experiences of panel to the inspector. However, the chair and agency decision-maker have yet to meet since the merging of the panels, and this is a missed opportunity.
72. The post-adoption support service features motivated and skilled practitioners. Adopters seen during the inspection praised the support that they received from the local authority, providing examples of the authority's tenacious support to ensure that children received the help that they needed. A comprehensive range of post-adoption support groups is available, including a weekly play session, a group for adopters who are waiting and an adult support group. Social workers apply their learning and experience effectively in their direct work with families. Inspectors saw examples of families supported to manage complex behaviours. When specialist support was required, this was readily available either through the local CAMHS service, or through a wide spectrum of commissioned provision.
73. There have been no adoption disruptions in the two years preceding the inspection, indicating that post-adoption support in place for children and families is effective.
74. Good use is made of the adoption support fund in order to provide specific therapeutic interventions for children and to provide training and support to parents. Adopters highly rate the service that they receive from Southwark, informing the inspectors that 'they get things done'.

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

75. Managers, social workers and personal advisers are highly committed to supporting young people leaving care, so that they achieve well and make a successful transition to adult life. New management arrangements and the recently established dedicated leaving care team are improving the quality of support that young people receive and building on areas of good performance.
76. Managers are developing a positive culture that is improving the services available to care leavers. However, the support that care leavers receive is inconsistent, and, for too many, it does not enable them to make sufficient progress across the different aspects of their lives.
77. The quality of pathway planning to meet young people's needs is too variable. As a result of recent action by managers, the majority of young people now have an up-to-date pathway plan. However, the needs of a significant minority of young people are not sufficiently understood by staff and, as a result, planning does not fully reflect the specific needs of individuals. Plans are not always clear as to the specific measures that staff will pursue to reduce any evident risks to young people, such as repeat missing episodes or time out of education.
78. Personal advisers and social workers are increasingly having regular contact with young people on their caseload, and most young people are seen regularly. However, for a significant minority this is not the case. In some instances, managers are slow to intervene when staff are not progressing work in a timely way. This results in delays to young people receiving the support and help that they need to move forward in their lives.
79. Young people who spoke to inspectors hold mixed views about the quality of the relationship that they have with, and the support that they received from, their personal advisers or social workers. Some feel that staff leave them to fend for themselves and that they have too little communication with their worker, in particular when they turn 18 years of age or are at university. However, others hold their social worker or personal adviser in very high regard and gave examples of when they have benefited from very effective help, for example in being supported to find suitable accommodation and training.
80. There is a good range of financial support available to young people to support their transition to adulthood, such as travel costs to attend college, accommodation costs during university holiday periods and allowances to set up their first home. However, young people are not sufficiently aware of their entitlements, including the financial support available to them, if they attend

university, or the practical help that they should receive when they become 18 years old. In a minority of cases, young people do not receive sufficient help to ensure that basic, essential necessities, such as their passport, national insurance number and bank account, are in place.

81. Most young people receive good support to achieve their education, employment and training (EET) goals, benefiting from the specialist advice and guidance available. Published data shows that the proportion of young people in EET is around the same as that in other areas. However, more recent local data shows that approximately three quarters of young people aged over 19 years old are in some form of EET, which is a comparatively high proportion. Most young people who spoke to inspectors feel that they receive good support to progress in their education and career goals, although this is not universal. In a minority of cases, there are delays in putting the additional help in place that young people need to achieve their next step in EET.
82. A good proportion of young people are at university. However, young people were not wholly positive about the support that they receive while at university. For example, some reported a lack of help in navigating the housing options available, and others feel that they are left on their own when they begin their courses.
83. Young people who spoke to inspectors feel safe where they live. Social workers and personal advisers provide effective support to young people that helps them to find accommodation that best meets their needs. As a result, a good proportion of young people live in suitable accommodation. Staff effectively promote the option of young people remaining with their foster carers when they turn 18 years old. Consequently, approximately a fifth of current care leavers are doing so. Bed and breakfast accommodation is never used, and use of houses of multiple occupation is extremely rare.
84. At the last inspection, care leavers felt that they did not receive enough support in preparing for independent living. Young people who met with inspectors at this inspection had very mixed views on the support that they receive to live independently, and they feel that they need more help, particularly in managing money, despite pre-tenancy training and training in budgeting being available.
85. Young people have their basic health needs met, and most are registered with a local doctor and dentist and are aware of the range of help available so that they can live healthily. Young people receive regular reminders from workers about their health appointments, and, increasingly, those aged 17 are attending their health checks and receiving a summary of their health histories so that they are well placed to manage their own health appointments.

86. Young people are not sufficiently aware of how to complain, should they be dissatisfied with aspects of the support that they receive. Some feel that they are not listened to when they express dissatisfaction over aspects of the service that they receive and they find managers hard to reach.

Leadership, management and governance	Good
<p>Summary</p> <p>The local authority has a comprehensive understanding of the complex needs of the community and has developed adaptable and creative services to respond to local need. The senior leadership team has been strengthened, and four new assistant director posts were appointed to in 2016. Significant improvement work in recent months has enabled service performance reviews to be completed and compliance and quality issues to be addressed. Service plans are in place to address all of those areas of practice that are not yet consistently strong. Progress in performance can be seen in the adoption service, the front door and the MASH. However, services for children looked after and care leavers are still too variable. Services to survivors of female genital mutilation and children at risk of sexual exploitation demonstrate improvement and strong practice.</p> <p>A culture of high support and high challenge is promoted, and areas of good practice are celebrated and learning widely disseminated. Innovative practice is actively sought and developed, for example, with the award winning 'Pause' project. This outward-looking professional culture enables good social work to flourish in many areas.</p> <p>The newly formed quality assurance unit provides good performance data and undertakes valuable monitoring and practice reviews. Following a transfer to a new electronic case management system, data has not yet been fully cleansed. Consequently, child in need and children's review information is not yet available in a comprehensive format. This remains a significant gap.</p> <p>There is a strong, shared corporate ownership and ambition to improve outcomes for children, extending across the local authority partnerships. Strong, passionate and committed political support and challenge are enabling the local authority to make continuous improvements. Mature strategic partnerships are a strength and translate into good operational practices.</p> <p>Children and young people are at the heart of all services. They are involved in all areas of decision-making, service planning, scrutiny and challenge and are fully integrated in the development of children's services.</p> <p>Workforce development continues to be a priority. Promoting the 'social work matters' model of practice and creating widely available learning and development opportunities are having a positive impact on sickness rates and staff turnover. Although some children reported that they have had a high number of social workers, this is partly attributed to internal changes, which have been made to improve the quality of services.</p>	

Inspection findings

87. Since the last inspection, the senior leadership team has changed. The strategic director of children's and adult services, the statutory DCS, was appointed in October 2014, and a director of children and families' services was appointed in June 2016. Following these appointments, there was a finding of too much inconsistent practice across services. This stems from the mixed impact of the implementation of the 'social work matters' practice model, introduced in 2014. This model is based on systemic practice, small teams, widespread use of clinical and group supervision and evidence-based approaches.
88. The senior management structure has been strengthened over the last year to accelerate change and improvement. Four new assistant director level posts have been created and appointments made. The progressive impact of this additional senior management investment is becoming evident. There is rigorous and regular oversight of the performance of frontline managers, and weaker performance is being determinedly addressed through high support and high challenge. The full impact for children of this rigorous management approach is yet to be demonstrated across all service areas.
89. Strong political leadership in the local authority demonstrates commitment and ambition for vulnerable children. This thread is evident throughout all of the local authority's priorities and plans. Members have protected the children's social care budget for a further three years, allowing substantial continuing investment in workforce transformation.
90. The lead member for children is an active participating observer on the LSCB and the corporate parenting committee, demonstrating a thorough understanding and knowledge of the priorities of children's services. The chair of the scrutiny committee for children is also highly effective and has been instrumental in developing innovative service models. This supports a strong multi-agency approach to issues affecting vulnerable children in the local authority.
91. A comprehensive joint strategic needs assessment (JSNA), which included a consultation with more than 1,000 children, parents, carers, staff and practitioners, informed the local authority's formation of its strategic priorities for children.
92. Children are very active in all of the local authority meetings that affect them. 'Speakerbox' and 'Changemakers' are participation forums that children and young people regularly attend, to give advice and challenge. Young people consistently told inspectors that they feel valued and respected when they attend. Children are also involved in the recruitment and training of staff, new policy developments and ways of working. One of many examples of their impact is the way that care leavers' exit interviews are conducted. This has

improved through better engagement with young people. This ingrained participation is a real strength in the local authority.

93. Social work in Southwark is largely child focused, and the views of children are actively sought and demonstrated. Currently, 96% of children looked after participate in their reviews. Further work is under way to support children in attending their child protection conferences and core groups. However, in the care teams, the voice of children is not sufficiently clear in assessments and plans.
94. Mature strategic and operational partnerships are prominent. Partnership working is strong through all services provided for children. Working arrangements between highly committed elected members, the LSCB chair, the strategic director of children's and adult services and the chief executive are compliant with statutory guidance. These arrangements are underpinned by appropriate formal governance protocols, so that senior officers are regularly held to account. Recent effective partnership service delivery has been evidenced in services, effectively addressing female genital mutilation and child sexual exploitation. Both of these areas have been strengthened and improvements made to frontline practice and services through an embedded multi-agency approach.
95. The local authority has recently been successful in three Department for Education (DfE) innovation bids. Bids feature improved services to care leavers, expansion of the family group conference offer and a further extension to the 'Pause' project, working with women who are vulnerable to having children repeatedly taken into care. This demonstrates commitment and high ambition for continuous improvement and development of services. The senior leadership team is passionate that service delivery continues to meet the emerging needs of vulnerable children and families in Southwark. Senior leaders ensure that they maintain a direct line of sight to frontline services, and they meet regularly with children and young people from 'Speakerbox' and other users of the services that they provide.
96. The recently formed quality and performance improvement service has introduced a framework that brings together three main elements of performance management: quality assurance, practice review and regular performance monitoring. Examples of the framework include recent 'deep dive' scrutiny of the front door and early help services. This has resulted in positive changes in the MASH and instigated an early help service review.
97. Performance data is provided to managers at all levels and to support scrutiny in council meetings. This is largely provided in a useful and clear format. Recently, the corporate parenting committee requested case studies to help its understanding of the meaning of the data produced, which were subsequently provided. Data cleansing is ongoing in important areas, such as

child in need performance data. However, the voices and experiences of children are not sufficiently prominent in performance reports.

98. The provision of high-quality placements for children looked after, particularly for adolescents, is insufficient. The sufficiency strategy for post-16 accommodation for young people leaving care has recently been refreshed. The needs analysis and scoping involved a wide range of relevant parties, including the integral participation of young people. The strategy aims to rationalise current service provision to ensure that it is fit for purpose for the future. The commissioning and provision of early help services are also under review.
99. There is a comprehensive workforce development plan, which covers a wide range of learning opportunities. An academy is currently under development, which will further strengthen the considerable training and development opportunities already available for staff and students. The extensive learning and development programme of the LSCB complements the local authority programme. This provides access to a broad range of learning opportunities, including short and long courses, accredited and non-accredited programmes, bite-size sessions and regular conferences.
100. Expected standards of social workers' and managers' performance are high. Careful support is provided to staff who underperform, and assertive action is taken to manage staff who are unable to improve. However, there is currently no skills audit or detailed record of social workers' or managers' current levels of training and development.
101. Most staff who spoke to inspectors feel well supported. Low sickness levels and a comparatively low turnover of social workers support this finding. Retention rates of social workers are relatively good, compared with similar London boroughs. Expectations of social workers' standards are high, and managers are actively supporting and challenging under-performance, resulting in some staff turnover. There are too many changes of social workers for children who are looked after, but this is primarily due to recent internal challenges and changes, intended to stabilise the allocation of social workers over the long term. Weekly practice supervision sessions in the safeguarding and assessment sets include clinical and advanced practitioners, enabling staff to examine and hypothesise about the impact of their work with children and families. However, this practice model has not yet been consistently applied within the care and care leavers' sets. In addition to the weekly sessions, monthly one-to-one supervision takes place for most staff. There are some instances, particularly in the children looked after and care leavers' service, where drift and delay in some service provision for children are evident as a result of weaker management oversight.
102. Due to the inconsistent implementation of the 'social work matters' model, the role of the clinical practitioner has recently been reviewed. The outcome was

the creation of a clinical lead post, which aims to improve standards and support clinical practitioners' learning and development. This initiative, coupled with the rigorous support and challenge of poor performance of some frontline managers, further demonstrates the ambition of senior leaders to provide good-quality services to all vulnerable children.

103. Senior leaders know themselves well. Strategic documents and action plans succinctly draw together areas for improvement. These prioritise similar areas highlighted in this inspection. Substantial improvements have been achieved in the adoption and permanence service and the MASH. Service developments and improvements have been secured through working effectively with partners, creating a culture of continuous improvement and, above all, having an ambition for improved outcomes for children at the heart of services. A high number of children looked after attend good or outstanding schools in the borough, and additional, focused home tuition is provided to boost core subjects. The local authority's virtual headteacher is proactive in ensuring effective provision.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is good

Executive summary

The independent chair of the LSCB provides strong leadership. Since his arrival in 2013, he has brought energy, commitment and determination. This has resulted in a strong focus on safeguarding children, a streamlined structure, clear priorities and a culture of challenge across the partnership. The impact of the LSCB's work is evident across a range of areas. There are well-established links between the LSCB, the Health and Wellbeing Board and other relevant strategic forums. These arrangements allow the Board to ensure that children's safeguarding issues remain high on everyone's agenda. Children's and adults' safeguarding arrangements have been aligned to ensure greater synergy and a focus on the family. This reduces duplication, improves efficiency and promotes a shared understanding of issues such as gangs and female genital mutilation.

The LSCB has completed an ambitious programme of audits. These, together with ongoing scrutiny of issues and information from performance data, ensure continuous and effective monitoring of frontline practice. A new performance management framework is helping to ensure greater understanding of practice. However, further work is required to embed the use of data in the Board's sub-groups.

The Board has been instrumental in developing work around key issues, such as radicalisation, female genital mutilation, gangs and child sexual exploitation. There has been an extensive training programme and media campaigns on child sexual exploitation, resulting in increased identification and more prosecutions.

The group of young people who work with the board, the 'Changemakers', is a valued and integral partner in delivering the safeguarding agenda. The group undertakes meaningful and innovative work that has impacted on partners' understanding of issues and resulted in changes to services.

There is a comprehensive LSCB learning strategy, aligned to the Board's priorities. Training is informed by learning and annual evaluation of impact. This work now needs to be built on, with closer analyses of the needs and gaps in the workforce across the partnership.

The annual business plan is not sufficiently clear and lacks measurable outcomes. Risks and concerns are not always explicit. As a result, the system for monitoring important issues and actions requires strengthening.

Recommendations

104. Embed the performance framework into the work of the sub-groups, ensuring that relevant performance data informs analysis and evaluation of services.
105. Undertake analysis of workforce training needs and gaps in order to ensure that training is relevant and targeted effectively.
106. Ensure that the annual business plan is specific, measureable and time-limited and strengthen the systems for tracking actions, risks and concerns.
107. Continue to develop a clearer understanding and more appropriate application of thresholds for referrals to children's social care across partner agencies.

Inspection findings – the Local Safeguarding Children Board

108. The LSCB in Southwark has strong and effective governance arrangements to ensure that all partners are fulfilling their statutory duties to safeguard children. The chair of the LSCB provides strong and clear leadership. He is well respected and influential, and has relentlessly driven forward work to ensure improvements. This has resulted in a strong focus on safeguarding children, a streamlined structure, clear priorities and a culture of openness and healthy challenge across the partnership. The Board embraces continuous improvement, recognises areas for development and responds to ongoing emerging safeguarding issues across the local authority.
109. There is strong communication between the LSCB, the Health and Wellbeing Board, multi-agency forums and senior officers across the partnership. These arrangements allow the Board to ensure that children's safeguarding issues remain high on everyone's agenda. In 2015, the LSCB chair also became the chair of the adult safeguarding board. Since that time, work has taken place to bring the two boards and other strategic forums together. The community safety partnership, Safer Southwark, is now part of the adult safeguarding board. Revised sub-group arrangements mean that the two boards share relevant sub-groups, such as human resources, community engagement and practice, development and training. There is a shared partnership forum, and twice each year the boards come together to discuss priority areas of work.
110. While work is still taking place to finalise these arrangements, this alignment of the two safeguarding boards has resulted in greater synergy and a holistic focus on families. It reduces duplication, improves efficiency and promotes shared understanding and better joint working to address issues such as gangs and female genital mutilation. However, the governance protocol from 2014 has not yet been updated to reflect these changes.

111. The LSCB and the local authority hold each other to account. The LSCB chair works closely with the statutory DCS, the chief executive, cabinet members and the leader of the council. As a result, the Board is active and influential in planning and informing services.
112. There is a strong and engaged partnership. The LSCB includes a wide range of appropriate partners. Attendance at all meetings is high, and partners report that they attend regularly because the meetings are valuable. Board meetings frequently include more than 35 people. They are well managed and focused and include time for breakout discussions on key subjects. One partner described Southwark's approach as 'collegiate', and this is reflected in the number of different agencies chairing the 11 sub-groups and being involved in reviews and shared task and finish groups. An example of this is the current work to review the Board's oversight of children who have a disability.
113. The partners' commitment to the Board is apparent, not only in the time that they give to the LSCB, but also in the financial contributions made. The Board increased its budget in 2016–17, and partners have agreed additional core funding for 2017–18 in order to expand the support team for the children's and adults' safeguarding boards to include an additional analyst and two partnership officers.
114. The Board receives and reviews a range of relevant reports and updates that are scrutinised and challenged. An example of this is a report on private fostering arrangements. The Board's scrutiny led to awareness raising in the community and a greater understanding of how private fostering is identified. This has resulted in an increase in private fostering notifications.
115. While challenge and scrutiny are part of all of the Board's work, the system for tracking areas of concern and risks, through a forward plan and minutes of meetings, is not thorough enough. It does not sufficiently identify risks or those areas that the Board is concerned about.
116. There is a clear learning and improvement framework, and the partnership embarked on an ambitious programme of multi-agency audits in 2015. Audits have included child protection processes, parental mental health, home education, children missing education, child sexual exploitation, child protection plans for children who have a disability, adolescents, neglect and the MASH. These, together with regular reporting of single-agency audits, ensure continuous and effective monitoring of frontline practice.
117. The Board has introduced a performance management framework. This helps to ensure a greater understanding of practice and informs challenge. An example of this is the Board's concern about an increase in children's social care referrals. This challenge led to a MASH audit and a revision of the threshold document, and helped the local authority to identify changes to the

management arrangements for early help services. While the Board routinely considers performance data, it acknowledges that more work is needed to embed data into the work of sub-groups. Education and training data requires strengthening, and the multi-agency sexual exploitation (MASE) panel and human resource dashboards require further work to align partners' data.

118. Partner agencies prioritise safeguarding. The annual section 11 audits of safeguarding arrangements, undertaken by most agencies, demonstrate this. There is good analysis and scrutiny through a multi-agency challenge panel. All partners have individual action plans, and the Board collates key themes to inform its work. The Board recognises that this process needs to be extended to schools and more voluntary and community sector groups across the local authority. A task and finish group has been set up to explore how changes can help these agencies to become more involved in the process.
119. The child death overview panel (CDOP) and its sub-group, the neonatal death overview panel (NDOP), are shared with another local authority area. They are effective and benefit from a broader understanding of a larger population. They demonstrate learning and impact and are integral to the Board's work.
120. The SCR group provides a rigorous system for consideration of serious incidents and dissemination of learning from all case reviewing activity. During the inspection, the SCR for Child U was published. It highlights improvements required in information sharing and work with gangs and knife crime. Learning events, as part of the SCR process, have taken place, and an action plan is about to be implemented.
121. The Board has been instrumental in developing work on key issues, such as preventing violent extremism and female genital mutilation. It has undertaken considerable work on child sexual exploitation and established a tactical MASE group at director level, which reports to the Board. All agencies have given a pledge to tackle child sexual exploitation. There has been a large-scale training programme. The risk of child sexual exploitation is part of the school curriculum and an extensive media campaign included e-newsletters to thousands of residents. As a result, there are improved understanding and identification of child sexual exploitation, and this is evidenced by an increase in prosecutions and coordinated disruption activity across the borough.
122. The young people's group working with the board, the Southwark 'Changemakers', is a valued partner in delivering the safeguarding agenda. The group has representation at the chairs' sub-group, and young people regularly present their findings to the Board on the broad range of topic-based work that they are doing. Since the beginning of 2016, the group has undertaken meaningful and innovative work, which has impacted on partners' understanding of issues. A good example of this is the current work to develop a range of text messages to help girls to support peers who might be involved in child sexual exploitation. The group of 12 'changemakers' has

close links to other young people's engagement groups and, as a result, is able to reach a large population of children. This is illustrated by the group's survey of 800 children to capture the issues most important to children across the borough.

123. There is a clear and comprehensive LSCB learning strategy, aligned to the Board's priorities. It includes all levels, from practitioners to senior managers, the Board and elected members. Partners are involved in the commissioning of training to ensure that external training reflects Southwark issues and ways of working. A four-stage evaluation process evaluates the impact of training on practice and an annual evaluation, with other learning, informs the annual training calendar. However, a more detailed needs and gap analysis of the workforce is now required to ensure that people are receiving the training that they need and to inform the number of courses required.
124. The LSCB annual report 2016–17 provides a rigorous and transparent overview of its work. Findings from the report inform the annual business plan, which details work in each of the six priority areas, and this underpins work plans for each of the subgroups. However, while all of the actions within the Board's control have been completed, the business plan does not include timescales or identify who is taking forward actions. This makes it difficult to ensure that work is on track.

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 that 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 whom it is trying to help, protect and look after.

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

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

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

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

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