Brighton and Hove City Council

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

and

Review of the effectiveness of the local safeguarding children board[1]

Inspection date: 14 April – 8 May 2015

Report published: 22 June 2015

Children's services in Brighton and Hove require improvement to be good
There are no widespread or serious failures that create or leave children being harmed or at risk of harm. However, the authority is not yet delivering good protection and help for children, young people and families. Good leadership means that children and young people looked after, those returning home and those moving to or living in permanent placements outside of their immediate birth family have their welfare safeguarded and promoted.

1. Children who need help and protection		Requires improvement
2. Children looked after and achieving permanence		Good
	2.1 Adoption performance	Good
	2.2 Experiences and progress of care leavers	Good
3. 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.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates two children's homes. Both were judged either good or outstanding in their most recent Ofsted inspection.
- The previous inspection of the local authority's safeguarding arrangements was in May 2011. The local authority was judged to be adequate.
- The previous inspection of the local authority's services for looked after children was in May 2011. The local authority was judged to be adequate.

Local leadership

- The Executive Director of Children's Services has been in post since July 2013.
- The chair of the Local Safeguarding Children Board (LSCB) has been in post since April 2013.

Children living in this area

- Approximately 50,000 children and young people under the age of 18 years live in Brighton and Hove. This is 18% of the total population in the area.[3]
- Approximately 20% of the local authority's children are living in poverty.[4]
- The proportion of children entitled to free school meals:
  - in primary schools is 15% (the national average is 17%)[5]
  - in secondary schools is 14% (the national average is 15%)
- Children and young people from minority ethnic groups account for 16%[6] of all children living in the area, compared with 22% in the country as a whole.[7]
- The largest minority ethnic groups of children and young people in the area are Any other White Background (4.1%), and White and Asian (2.9%).[8]

[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.
[3] Mid-2013 population estimates.
[4] www.gov.uk/government/collections/households-below-average-income-hbai--2.
[5] School census data, January 2015 (including academies and free schools).
[6] 2011 census.
[7] DC2101EW – Ethnic group by sex by age.
[8] 2011 census.

- The proportion of children and young people with English as an additional language:
  - in primary schools is 13% (the national average is 19%)[9]
  - in secondary schools is 11% (the national average is 14%).[10]
- All of Brighton's minority ethnic communities grew significantly in number and proportion between 2001 and 2011, with the exception of the White Irish community. The largest increase in the number of people in an ethnic category between 2001 and 2011 is in the Other White category, which rose from 8,041 to 19,524.

Child protection in this area

- At 31 March 2015, 1,479 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 1,412 at 31 March 2014.
- At 31 March 2015, 309 children and young people were the subject of a child protection plan. This is an increase from 288 at 31 March 2014.
- At 31 March 2015, 16 children were living in a privately arranged fostering placement. This is a reduction from 17 at 31 March 2014.

Children looked after in this area

- At 31 March 2015, 481 children were being looked after by the local authority (a rate of 95.2 per 10,000 children). This is an increase from 465 (92 per 10,000 children) at 31 March 2014.
  - Of this number, 268 (or 55.7%) live outside the local authority area.
  - 39 live in residential children's homes, of whom 92.3% live out of the authority area.
  - Seven live in residential special schools,[11] of whom all live out of the authority area.
  - 387 live with foster families, of whom 56.1% live out of the authority area.
  - Five live with parents, of whom 20% live out of the authority area.
  - Eight children are unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been 52 adoptions

[9] School census data, January 2015 (including academies and free schools).
[10] School census data, January 2015 (including academies and free schools).
[11] These are residential special schools that look after children for fewer than 295 days.

- 28 children became the subject of special guardianship orders
- 180 children ceased to be looked after, of whom 3.9% subsequently returned to be looked after
- one child or young person ceased to be looked after and moved on to independent living[12]
- no young people ceased to be looked after and are now living in houses of multiple occupation.

[12] Based on Reason LAC Episode Ceased.

Executive summary

The current leadership team has implemented well-targeted plans effectively and made steady improvements to the quality of children's social care. However, some core functions still require improvement to be good. The senior management team has recognised this. It is now making good use of performance and quality assurance processes and had identified the areas for improvement, recommended in this report, prior to the inspection. One of the areas requiring improvement is that too many children are becoming subject to a child protection plan for a second or subsequent time as a result of child in need work not being sufficiently robust. Plans to address these deficits through a new model of practice are well advanced. Positive improvements include the effective multi-agency safeguarding hub (MASH), where appropriate child protection thresholds are consistently well applied.

Elected members are passionate and actively involved as corporate parents. They engage well with young people and take their views seriously. Members take an active role in quality assurance activity and have an appropriate level of understanding of frontline practice.

Since the last inspection, the senior management team has largely changed. The vast majority of recommendations have been met but two issues remain. The quality of supervision and management oversight at team level remain as areas for improvement despite significant investment in specialised training. Examples of where improved practice is now embedded include the independent reviewing service and the routine consideration by social workers of children and families' diverse needs.

When children and young people go missing, the authority's response is not yet sufficiently consistent or robust. All young people looked after are offered a return interview but the intelligence from those interviews is not yet systematically drawn together and used as effectively as it could be. Managers are aware of this and are currently commissioning a service to address the issue.

Partnership arrangements work effectively at both strategic and operational levels. Work to identify and address child sexual exploitation is well established, of good quality and has strong levels of multi-agency engagement. As a result, actions to protect young people from sexual exploitation are prompt and comprehensive. The council has responded well to the risks of radicalisation and wide-ranging multi-agency work effectively identifies and monitors those involved. A wide range of specialist assessment and support services add value and impact to core services.

When children are at risk of significant harm, thorough, timely strategy meetings and child protection investigations effectively assess risks. Children are routinely seen and issues of consent are dealt with thoroughly. Multi-agency involvement is wide ranging and section 47 enquiries are of good quality and are clearly recorded. However, there are too many delays in convening initial child protection conferences and performance in this area has recently declined.

Social workers work well to support families to make positive and necessary changes through formal child protection processes. When child protection plans end, the support provided under child in need arrangements is not always sufficiently robust to help families sustain the improvements made.

Children in need cases are appropriately assessed and held by qualified social workers. Where statutory involvement is not required, children needing help benefit from an early help assessment to identify their needs. The needs of children with a disability are assessed comprehensively and they are provided with a wide range of services that meet their needs.

Management oversight in some teams is not rigorous enough and the rationale for making decisions is not always clear on case files. Supervision by some managers does not challenge social workers where the progress of plans is delayed or drifting. The allocation and completion of children in need assessments is not always prompt and too many assessments take too long to complete. Where allocation is delayed, children may not be seen as quickly as they should be.

Children looked after achieve well in education compared with their peers. The virtual school provides good support and oversight taking individual needs into account. Attainment at Key Stage 4 is particularly good compared with national averages and represents significant achievement since the last inspection. The attainment gap for children looked after at Key Stage 2 is narrowing. Good quality practice and strong assessments result in children being matched and placed with their prospective adopters in good time. Adoption is given appropriate consideration for all children needing permanence. The authority does not yet have a sufficiently robust system to track and monitor the promptness of permanency planning. Assessments of adopters are robust and timely. Adopters are able to access a wide-ranging offer of support and express high levels of satisfaction with the service they receive.

The authority has high aspirations for its care leavers and supports them well. This is reflected in the numbers of young people who are engaged in employment, education and training. Tenacious efforts are made to keep in touch with care leavers and young people value the support they receive. High numbers of care leavers remain with their foster families after they are 18. However, presently there are too few local foster carers for older young people with complex needs. The engagement of care leavers in service design and influencing future practice is good, with clear impact. A small number of care leavers experience a delay in being allocated appropriate supported accommodation.

Recommendations

1. Ensure that when children cease to be the subject of a child protection plan, their families are given the priority and support they need to maintain the changes they have made.

2. Ensure that where a child requires a child in need assessment they are seen and spoken to promptly.

3. Ensure that managers monitor and track the timely completion of assessments so that needs and risks are identified promptly.

4. Improve the timeliness of initial child protection conferences so that multi-agency plans to meet children's identified needs and reduce risks, can be put in place at the earliest opportunity.

5. Improve the quality of management direction and oversight of cases to reduce the drift in plans experienced by some children.

6. When children go missing from home, ensure that they are offered a visit on their return to assess risks they may have been exposed to and to inform plans for them. Centrally analyse the records of these visits to help reduce risks to other children and young people.

7. With partners, review the pathways for early help to reduce the high numbers of inappropriate referrals that are made to the MASH.

8. Ensure that frontline managers provide rigorous, reflective and risk-focused supervision to social workers. Establish a supervision audit cycle to oversee frequency and quality.

9. Recruit and retain sufficient numbers of foster carers to meet the needs of young people with complex needs.

10. Ensure that permanence planning is undertaken promptly and that a tracking system is implemented to monitor this.

11. Increase the availability of supported accommodation for care leavers so that young people are promptly allocated supported accommodation that meets their needs.

Summary for children and young people

- Brighton and Hove City Council has made a lot of progress since its last inspection but some things still need to be improved.
- When children are at risk of harm, social workers recognise it and quickly take all the correct actions to protect them. Managers need to become quicker at organising the meetings where it is decided whether a child needs to have a child protection plan.
- Social workers, police and other professionals in the city work well together to know which young people are at risk of being sexually exploited. If a young person is being exploited, they take the right actions to protect them.
- The council needs to improve the way it helps families to continue with the changes they have made after their children's child protection plans end.
- The managers of social workers need to improve their oversight to ensure that children's plans are making a positive difference.
- Social workers who inspectors talked to know the children they work with well and could show inspectors the work they had done with them.
- Social workers are good at quickly finding new families for children who need to be adopted. They are also good at explaining adoption to children and making sure they understand why they can't stay with their birth family.
- Children who are disabled have social workers who understand their needs and are good at assessing with them what services will help them and their families best.
- Children in care in Brighton and Hove do well at school and achieve good results in their tests. They do not get excluded very often and their attendance is good. Social workers support them to attend regularly if they find that difficult.
- The council needs to recruit more foster carers in Brighton and Hove, especially for young people who have many difficulties.
- When young people leave care they receive good support and are helped to become independent at a pace that suits them. Personal advisers are very good at keeping in touch with young people when they leave care.

The experiences and progress of children who need help and protection

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

Summary

Children, young people and families receive an inconsistent response from the assessment team. Children at immediate risk of harm are responded to promptly. Other children, however, wait too long for assessments to commence and their needs to be understood, and for plans to be put in place to support them. Practice and intervention with families in the children in need teams is variable. High numbers of children become subject to a second or subsequent child protection plan or are re-referred to social work teams because lower level intervention is not always helping families to sustain improvements.

Practice managers do not consistently drive forward plans for children or provide appropriate challenge to workers about their practice. This means that some plans drift and children do not get the help they need when it is first identified.

Not all children who go missing from home are offered a return interview.

A wide range of early help services is available to children and their families. The coordination of these services through the early help hub is increasing the numbers of children who receive help. The local authority is beginning to review the impact of these services.

The recently established multi-agency safeguarding hub (MASH) ensures comprehensive information-sharing between agencies and makes prompt and appropriate decisions about whether families require social work or early help services. Not all professionals are clear about the thresholds for contacting the MASH, with high numbers of referrals re-directed to the early help hub.

Increasing awareness of child sexual exploitation by professionals from a range of agencies is leading to increased referrals to MASH and enabling help to be provided to children at an earlier stage. Effective monthly multi-agency child sexual exploitation (MACSE) meetings take place to consider all new referrals, have oversight of high risk cases and share information between professionals.

Good multi-agency work protects young people at risk of radicalisation. Comprehensive plans, effective use of legal orders and intervention work ensures they remain in this country and that their activities are closely monitored.

In response to local cases of female genital mutilation, prompt and effective partnership work has resulted in effective arrangements to reduce risk to children.

Inspection findings

12. The Early Help Partnership Strategy 2013–2017 clearly demonstrates the agencies commitment to providing early help support to families. A wide range of in-house and commissioned early help services are available. The partnership is beginning to evaluate this range of services to better understand their effectiveness in meeting children's needs and so reducing the demand on statutory services.

13. The MASH and an early help hub were both established in September 2014. A new threshold document published at the same time sets out referral pathways for both services. Some professionals remain unclear; since its introduction, on average 30% of referrals that come into the MASH with a request for a social work service do not meet the appropriate threshold. However, these referrals are swiftly forwarded to the early help hub for a comprehensive early help assessment. Engagement officers proactively contact families and professionals to coordinate early help support. As a result, increasing numbers of children and their families are offered an early help assessment.

14. Professionals working with children are supported by the early help weekly allocation meeting. This is a well-organised meeting that responds to and coordinates early help referrals effectively. Representatives from early help services attend the meeting and agree the most appropriate support that can be offered to families. Some services do have delays in allocating a service promptly to families, although professionals already known to families work hard to bridge gaps in these circumstances.

15. Social work expertise and advice is available in the MASH to support other professionals. The co-location of partner agencies ensures comprehensive information-sharing between a range of partner agencies that is timely and informs sound decision-making. In most cases, consent to share information is sought appropriately and where denied this is recorded clearly. MASH processes effectively identify children who are at risk of harm and cases are swiftly transferred to social work assessment teams.

16. When children are identified as being at immediate risk of harm by the MASH, the assessment teams take swift action. Strategy discussions are held promptly between police and social care practice managers. Their decisions are informed by detailed information shared by the MASH from a range of other partners. Child protection enquiries are comprehensive and risk is analysed well. Social workers see all children within the household alone and carefully consider their views and experiences. Threshold decisions about ongoing risk are appropriate, although timescales for convening a child protection conference are inconsistent and have deteriorated over the past 12 months. The percentage of initial child protection conferences taking place within 15 working days of a strategy discussion dropped from 77% in March 2014 to 52% in February 2015. This results in delay in multi-agency plans being drawn up to reduce risk within these families.

17. Despite the prompt response to children at high risk of harm, other children receive an inconsistent response from the assessment teams. This is a particular issue where risk or need is assessed by the MASH to be at a medium or low level. Some children wait too long for a single assessment of their needs to begin. At March 2015, only 49.7% of children had their needs assessed within an appropriate timescale. In cases sampled, the interval between the referral and the child being seen was too long, taking into account the reason for referral and known family history. A re-referral rate of 30% at 31 December 2014 is an improvement from 33% in 2013–14 but is higher than the national average of 23%.

18. Although many assessments are taking too long to complete, the majority of those seen are of good quality, with careful consideration of family history. There is little evidence of research being used in these assessments, but analysis is thoughtful and appropriate, with outcomes clearly identifying risk and needs of children well. Cultural and language differences are appropriately considered within assessments and services provided address the diverse needs of families. In the majority of cases seen, social workers listened to children and considered their thoughts, fears and wishes well in assessments. The views of fathers and those parents who do not live in the same household as the child are included in more recent assessments. Specialist assessment services such as the Early Parenting Assessment Programme, Looking Forward, the Clermont Unit and the children with disability team all bring additional robustness to assessments due to their individual specialism for particular areas of vulnerability. The emergency duty team responds proportionately to presenting risks and provides daytime staff with prompt updates on actions taken.

19. When children are the subject of child protection plans, there is increasing oversight by child protection chairs to ensure that plans are progressed. The majority of child protection plans are clearly focused on reducing identified risks to children. Core groups meet regularly to progress these plans, with generally good attendance from professionals who are known to the family. Parents are routinely invited and a large majority attend. Minutes from core group meetings are detailed but do not always provide an analysis of the impact on the child of the actions taken and make it clear to parents the success or otherwise of the progress being made.

20. Child protection conferences are well attended by professionals known to the child and where they do not attend reports are routinely provided by most agencies. Partner agency attendance and contribution are monitored effectively by the relevant agency safeguarding lead. This has resulted in increased contributions from GPs. Increasing numbers of children are supported to attend and contribute to child protection conferences and are routinely offered the support of an advocate. The local authority has recently surveyed those who have attended and is planning to respond to the issues raised in this survey.

21. High numbers of children are made the subject of repeat child protection plans. During 2014–15, this affected 81 children (22% of children subject to child

protection plans). This is a slight decrease from 2013–14 performance of 26.5%, but is higher than the national average of 16%. The local authority has analysed the reasons for the need for the repeat child protection plans. While some were found to have stepped down too early, following only a brief improvement, the large majority identify the recurrence of domestic abuse, parental mental ill-health or relapses in misuse of drugs or alcohol.

22. The prevalence of domestic abuse, parental drug or alcohol misuse and the impact of parental mental ill-health are known. Of the children made subject to a child protection plan from April 2014 to March 2015, 51.5% featured domestic abuse and 35.7% recorded parental mental ill-health. Parental drug and alcohol misuse were factors in 29.6% and 23.5%, respectively.

23. A range of services is in place to support those families where domestic abuse has an impact. These include services to support victims and children and statutory and non-statutory programmes for perpetrators of domestic abuse. Arrangements to share information between professionals and coordinate support to victims of domestic violence at multi-agency risk assessment conferences (MARAC) are effective.

24. Drug and alcohol services are available but services to support parents who have mental ill-health but who are not eligible for an ongoing service from adult mental health services are limited. The majority of services are primarily available when risks to children are high. The local authority is in the process of reviewing its commissioning arrangements to ensure that services are effective in helping families to sustain improvements when high-level risks have reduced.

25. Practice and intervention with families in the children in need teams is variable. When children's cases are stepped down from child protection plans, the support they receive is inconsistent. This means that families are not always supported effectively to sustain changes that they have previously made while subject to a child protection plan. This contributes to the high rate of repeat child protection plans.

26. Children subject to child in need plans are not given the same priority as those subject to child protection plans. Not all children who require a child in need plan have one in place. Initial plans that are in place are usually of good quality and well informed by assessment. Children's needs and potential risks are well identified. However, the subsequent work with families varies, is often reactive to crises within the family and does not always provide support in a timely manner to prevent such crises. Some cases are closed too early by the children in need teams and an arrangement for continuing support to the family is not in place. However, some good examples were seen where networking meetings agreed the range of support that would continue to be available to families when cases closed to social work services.

27. A major contribution to the inconsistency of practice is the weak quality of management oversight by practice managers in children in need teams.

Practice managers are not consistently driving forward plans and case discussion records make insufficient reference to the child's plan and whether it is having an impact in reducing risks and meeting children's needs. The rationale for decisions is rarely recorded. Managers' case direction is limited to identifying required tasks, often without clear timescales for their completion. This leads to drift and delay, particularly for children in need. Children at greatest risk benefit from challenging independent oversight by child protection chairs. Social workers report that they have regular opportunities to discuss cases in formal supervision, but that they are not always helped to reflect on the complexities of cases.

28. Children are routinely seen at home and alone and build trusting relationships with social workers through regular contact with them. Communication methods are carefully considered to meet individual children's needs and their stage of development. In many cases, particularly for children subject to child protection plans, direct work is helping children to understand their individual experiences and the plans for them. This enables their voices to be heard in plans to reduce the risks to which they are exposed. For very young children, purposeful observations are made of their interaction with parents.

29. Professionals across the partnership have a good awareness of child sexual exploitation. As a result, when children are identified as being at risk of child sexual exploitation, they are quickly referred to the MASH and escalated to social work teams. All young people identified as being at risk of child sexual exploitation are presented to the monthly MACSE meeting and the level of risk is agreed. These arrangements ensure that plans to reduce risk and support young people are routinely considered by a multi-agency group, including a local authority senior manager, who chairs the meeting. In addition, the meeting supports good information-sharing between agencies.

30. At the time of the inspection, 58 children were known to be at risk of or have suffered child sexual exploitation. Low numbers of boys are identified as being at risk of child sexual exploitation. The local authority recognises this as an area for development with its partners. The newly established joint police and social work Kite team works well with nine of the 14 young people at high risk of child sexual exploitation. The other five young people at high risk continue to receive support from social work staff with whom they have existing positive relationships. There are 35 young people assessed to be at medium risk of child sexual exploitation and nine at low risk. All of these children continue to be supported by multi-agency working arrangements and are allocated to a social worker. In cases seen by inspectors the coordinated support provided to these children is reducing the risks of child sexual exploitation effectively.

31. The WISE (What is Sexual Exploitation?) project undertakes direct work with young people and helps to reduce the risks of child sexual exploitation. Child and adolescent mental health services (CAMHS) do not currently provide therapeutic support to children affected by child sexual exploitation. However,

alternative spot purchasing arrangements are in place to provide this support to young people.

32. Not all children who experience episodes of being missing from home are offered a return interview. Practice and the analysis of return interview information are inconsistent. The local authority accepts that it cannot be assured that effective plans are put in place to reduce risks of further missing episodes or that potential risks of child sexual exploitation are identified as a result of this inconsistent practice. Funding has been secured to commission an independent provider to undertake all return interviews, including looked after children, to tackle this deficit.

33. The local authority maintains an up-to-date register of children missing school-based education. At the time of the inspection, 246 children were on this register. This includes 188 children who are electively home educated as well as those who receive home tuition due to their medical needs and those presently not on the roll of a school. The local authority has a clear definition of what constitutes children missing education that extends beyond those without a school place. The children missing education panel considers cases routinely and individual action plans are put in place with a nominated professional responsible for operational oversight.

34. Agencies demonstrate a tenacious approach in tracking children. The local authority takes decisive action to return children to school where home education is not meeting their needs and they are vulnerable. Good liaison and information-sharing between professionals is used to establish the whereabouts and status of children. Checks are routinely made with schools to confirm which children arrive at school. Cases where children do not appear in school are routinely followed up.

35. When 16- and 17-year-olds are at risk of homelessness, they are well supported by a range of youth services and many return home to live with their families. A small number of these young people are placed in suitable emergency accommodation before being referred to the MASH. At that stage, despite parents' consent, their legal status is not clear. When emergency accommodation is required outside of office hours young people are referred to the MASH the following day. Where these young people are vulnerable, they are referred promptly for a social work assessment. As well as being provided with accommodation, including becoming looked after where appropriate, young people are offered an advocacy service and appropriate support.

36. Good arrangements are in place to respond to cases when allegations are made about professionals who work with children. The local authority designated officer's (LADO) comprehensive awareness-raising activity has resulted in a range of referrals from various statutory and non-statutory agencies, including sports groups and faith organisations. Some recent joint working initiatives with the council's licensing department are also raising awareness of the LADO role.

Good quality multi-agency work underpins all work by the LADO and helps to protect children.

37. Effective work identifies children living in private fostering arrangements. They and their carers are assessed by social workers to ensure arrangements are safe and needs are identified. This is mainly due to increased awareness of local language schools that arrange for children from abroad to live with local host families under private fostering arrangements. Appropriate support to privately fostered children is in place in almost all cases, although not all children are visited as regularly as they should be.

38. The local authority, with its partners, have reacted promptly to local cases of concern by raising awareness and putting in place effective arrangements to reduce the risk to children at risk of female genital mutilation. In addition, well planned measures have been taken in response to the identification of a growing risk of radicalisation for some young people in the city. Wide-ranging and good quality partnership meetings develop, implement and monitor comprehensive plans to meet the needs of such young people. The authority has proactively used wardship proceedings to effectively restrict international movement of young people at high risk.

The experiences and progress of children looked after and achieving permanence

Key judgement	Judgement grade
The experiences and progress of children looked after and achieving permanence	**Good**

Summary

Robust work is undertaken to identify children at risk of becoming looked after. A range of services provides effective support to maintain them with their families where this is the right plan and is possible. Effective work with partners has resulted in cases where children need to be protected by court orders progressing through legal proceedings without delay. This enables children to be secure about their future and minimises uncertainty.

Effective work is undertaken to identify and reduce risks for children looked after who are most vulnerable to going missing, sexual exploitation and substance misuse. Children looked after are routinely offered an interview when they return from a missing episode.

The education of children looked after is supported well by a strong virtual school, resulting in high school attendance and no permanent exclusions. Educational attainment for children looked after at Key Stages 2 and 4 is strong. Children looked after have positive health outcomes as a result of good quality health assessments and plans. The council works well to provide services that support children's emotional well-being and mitigates against delay in accessing CAMHS.

The sufficiency duty is met, although recruitment to increase numbers of in-house foster placements has had limited impact. Foster carers receive good quality preparation and are well supported. Placement stability for young people with complex emotional and behavioural needs is not yet good enough.

Children placed for adoption are carefully and swiftly matched to appropriate adoptive parents and are well prepared for adoption. Assessments of prospective adopters are of at least good quality and are robust. Wherever possible, siblings are placed together.

Care leavers are supported to make a successful transition to independence and are well informed about their entitlements. Young people leaving care are encouraged to remain in care until they are 18 and a high number remain living with their foster carers in 'staying put' arrangements after that time. A higher proportion of care leavers are in education, employment and training than those in similar areas and in England overall. The participation of care leavers and looked after children is good and they influence service development.

Inspection findings

39. The local authority takes robust action to identify children and young people on the edge of care and, with partners, provides a wide range of effective services to prevent them becoming looked after. For example, the Early Parenting Assessment Programme assesses and supports young parents pre-birth and following the birth of their child. It is highly valued by colleagues and service users. In addition, family group conferences are used effectively to engage wider family members to address concerns about children.

40. Children most at risk of becoming looked after are considered at the children's social care planning panel, which determines whether additional work is required or whether to initiate a legal planning meeting. In all cases seen, children were looked after by the local authority where it was in their best interests. Thresholds for children to become looked after are appropriately and consistently applied by local authority staff. High numbers of children are looked after and the authority is aware that this is mainly due to increasing numbers of adolescents being accommodated.

41. Few children looked after return home to live with their parents on a planned basis. A small number of older looked after children (16–17-year-olds) return home on an unplanned basis. This means these returns are not informed by a social work assessment and support plan. Social workers do however provide ongoing monitoring and assistance and the young person's care placement is maintained while stability is tested.

42. Effective strategic and operational work with the Children and Family Court Advisory and Support Service (Cafcass) and the courts results in good and timely performance, with care proceedings completed in an average of 28 weeks. This is enhanced by the local authority legal adviser jointly chairing the Local Family Justice Board. Assessments and reports prepared by social workers for court proceedings are of a high standard overall. Social workers are supported by good advice from legal services in preparing them. The local authority promotes and supports family members effectively to become special guardians, with 132 children subject to an order as of 31 March 2015.

43. In almost all cases, children looked after are seen regularly by social workers who know them well and who see them alone where appropriate. Social workers develop positive and sustained relationships with children looked after in most cases. Case loads are manageable and allow time to undertake direct work. Historically children had too many changes of social worker and this meant work such as life story work was interrupted too often. Managers are currently implementing a new model of working that will minimise case transfer points and further support continuity of social worker for looked after children.

44. Where the permanence plan is for children looked after to remain within their extended family, network assessments to consider connected persons are of

good quality and include a detailed analysis of strengths and vulnerabilities. Plans to manage identified risk factors are included and appropriate.

45. A significant proportion (42% in the year ending December 2014) of young people looked after enter care as adolescents, with a range of risk-taking behaviours that includes substance misuse, going missing and criminal activity. For a few young people, this behaviour is directly linked to radicalisation and they make up a significant proportion of looked after young people known to the youth offending service. These young people benefit from the involvement of a wide range of professionals, including from the national anti-radicalisation intervention programme. Social workers are able to build positive relationships with the majority of young people that helps the young people to understand the consequences of their behaviour. In a few cases, despite strong efforts, social workers struggle to engage effectively with these young people.

46. Five young people became looked after as a result of being remanded in custody. In these cases, the council makes good efforts to visit young people and support them by facilitating contact with their relatives. The youth offending service works closely with the support through care team and with independent reviewing officers (IROs).

47. Risks to children looked after who go missing from care and those at risk of child sexual exploitation are promptly recognised, assessed and addressed by social workers. Information-sharing between partner agencies and parents and carers is well established and results in effective care plans that target and reduce risks. Following episodes of children going missing, return interviews are routinely offered and recorded by children's social workers. Information obtained from these interviews is used effectively to inform plans to reduce risk to the children. Secure accommodation is used appropriately where risks are high and alternatives are not sufficiently protective. Four young people have been placed securely in the last year.

48. Children looked after's initial health assessments are not as timely as they should be, particularly for children over the age of five. However, review health assessments are timely and of good quality, demonstrating that actions from previous assessments are acted on. Good multi-agency involvement informs health assessments and plans.

49. Social workers for children looked after who have emotional health issues access CAMHS promptly for an assessment, but the wait for treatment is often too long. Positively, and to mitigate against this delay, the authority provides a range of good quality services such as Clermont, which offers a selection of therapeutic interventions and assures prompt access.

50. The virtual school provides good support and oversight of children looked after's education. Each child is known well and good plans take their individual needs into account. Data are used effectively to review children's progress and the virtual school intervenes to help when their progress falters.

51. Children aged 11 and 16 achieve well compared with their looked after peers in similar areas and in England overall. Between 2012/13 and 2013/14, children's attainment at age 11 improved in reading, writing and mathematics to above statistical neighbours and the England average. In 2013/14, over 54% of children in care achieved Level 4 or above in these subjects compared with 44% of children looked after in other areas. The attainment of children at Key Stage 4 is good, with 26% gaining five GCSEs including English and mathematics in 2013/14 compared with 14% in England. This represents good improvements since the 2011 safeguarding and looked after children inspection, when attainment at Key Stage 4 was identified as a weakness.

52. Children in care make good progress from their starting points. Between the ages of five and 11, data shows that a good proportion make the progress expected of all children in reading, writing and mathematics. Further good performance is demonstrated at Key Stage 2 in 2013/14, when the attainment gap between children looked after and their peers narrowed by 10% from the previous year to 27% and was smaller than the attainment gap for children in care in similar areas.

53. Most personal education plans (PEPs) are of good quality and schools now routinely take the lead in completing them. In the few that are not good, children's views are not well represented and target setting is not always sufficiently detailed. The proportion of children looked after with an up-to-date personal education plan has improved, from 74% in October 2014 to 84% in April 2015. The pupil premium is used effectively to support children's academic progress and personal development, for example through providing additional tuition.

54. Children looked after's attendance at school is good and is overseen effectively by the virtual school, which intervenes at the first indication of a concern. Effective joint working between schools and social workers ensures that problems are identified at an early stage and that support packages are put in place to prevent exclusions. As a result, there have been no permanent exclusions of children looked after for five years.

55. Around three quarters of children looked after attend a good or outstanding school. Where a school is judged less than good, careful consideration is given to the individual circumstances of the child and the progress they are making before disrupting their education.

56. Children are supported and encouraged very well to participate in positive activities outside of school. The virtual school runs six after-school clubs including dance, athletics and table tennis. Here, children and young people develop new friendships and learn new skills.

57. Children looked after live in a good range of safe placements that are effectively overseen and monitored. Placement stability is not yet good but is improving. The rate of children having three or more placement moves is

11.9%, and is moving positively towards the national average level of 11%. The performance figure is distorted by the fact that when independent foster carers transfer to the council this registers as a placement change even though the child has not moved. Longer-term stability is showing an improving trend at 68.5% in February 2015 compared with 62.7% in April 2014.

58. Over half (55.7%) of children and young people looked after are placed outside of Brighton and Hove, but most live within 20 miles of the city. These young people are not disadvantaged by this and are able to access the same range of services as those living locally. Social workers visit young people regularly and most are able to maintain local school placements. Providers' inspection grades are routinely monitored and individual cases are reviewed where there are concerns about the quality of care or where inspection outcomes deteriorate.

59. Although sufficient placements are available and young people's views are taken into account when placements are made, the local authority recognises the need to recruit more local foster carers. Investment in council employed staff to tackle this has not been as effective as hoped for. There is particular need for carers for adolescents and an independent provider has been commissioned to develop recruitment strategies and increase the number of available placements.

60. The fostering panel is suitably structured, with appropriate representatives from diverse backgrounds. It carries out its core functions robustly and is well supported by an effective panel adviser. Legal advice is readily available where required. The panel is chaired by a committed and experienced chairperson. Reports to the fostering panel are of a high standard and the agency decision-maker considers each case thoroughly. As a result, decision-making is timely and robust.

61. Foster carers are well prepared, trained and supported by supervising social workers. They access a range of training to update their knowledge and awareness of issues affecting looked after children.

62. When children become looked after, the quality of care plans for them is good. In the vast majority of cases, they are comprehensive and appropriately detailed. However, not all care plans include specific actions to be taken or clear enough measures of progress. Care plans are reviewed effectively and in a timely way. Children are encouraged to have ongoing contact with their own families and friends wherever this is safe and appropriate. Where young people are able to express their views, these are taken into account in both case and placement planning.

63. The IRO service works well and effectively ensures that children's care plans progress without delay. The functions of IRO and child protection conference chairs were separated in September 2014 with a positive impact for children and their families. Additional IROs are now in post, which has resulted in manageable caseloads of around 70 children per IRO. As a result, IROs carry

out their core duties effectively and also engage with children looked after outside of their reviews to establish meaningful relationships and monitor the progress of their care plans.

64. IROs routinely provide constructive feedback to social workers, recognising good practice and raising management alerts where practice is below the standards required. A formal management alert system is used effectively to highlight concerns and ensure that improvements take place. For example, in several cases, IROs appropriately challenged or prompted social workers and managers to ensure that work was undertaken effectively, such as convening strategy meetings where children looked after were missing and ensuring that risk assessments were up to date.

65. The independent visiting service is a strength and benefits children looked after. There are 46 well trained and supported independent visitors who are matched to looked after children, and a further 32 currently being trained. Children looked after also benefit from good work to address issues of diversity delivered by the intensive placement team.

66. Case recording is not always good and at times is too brief. This is particularly the case for the recording of statutory visits and the representation of children's views and opinions. However, in the disabled children's service, recording is of good quality and is purposeful.

67. The views of children looked after are well represented through a long-established Children in Care Council (CICC). This is well structured, with three groups comprising different age bands of young people from diverse backgrounds. The young people are rightly proud of the wide range and high quality of materials that they have produced to inform others of what they do, including the pledge. A good example of their influence is the published guidance on pocket money for children looked after. The CICC is well supported by committed and enthusiastic staff, some of whom are care leavers. They ensure that children looked after participate in a range of positive activities – including being on the corporate parenting panel and staff interviews, as well as being part of a music band.

The graded judgement for adoption performance is that it is good

68. The local authority places children for adoption in good time and matches them carefully to adoptive parents who can meet their needs. Prospective adopters are recruited through a variety of means and a diverse range of adopters are recruited. Of the adopters approved in the last year, almost a third were identified as LGBT (lesbian, gay, bisexual or transsexual), which is a good reflection of the diverse local population. Performance on the adoption score card is broadly in line with both the England average and statistical neighbours. The average time between a child entering care and moving in with its adoptive family is 592 days, which is better than the national average. The average time between a local authority receiving court authority to place a child and the local authority deciding on a match is 225 days, which is slightly worse than the national average of 217 days.

69. In the past year, 52 adoption orders have been granted and 42 children have been matched with adoptive parents. At the point of the inspection, there was only one child waiting to be matched to prospective adopters. Where family finding processes are unable to match a child with prospective adopters, a suitable permanent alternative is secured within an appropriate timescale. The number of children for whom this change of plan is the case is broadly in line with statistical neighbours and the national average, at 15% of those with an adoption plan.

70. The local authority performance for placing children over the age of five is 8%, which is higher than both statistical neighbours and the national average. Family finding for all children, including those over the age of five, is proactive and thorough, with careful consideration of available families and robust matching. Good use is made of the National Adoption Register, newsletters and activity days, as well as web-based services such as 'Be My Parent' and 'Adoption Link'.

71. Currently, there is no mechanism for tracking whether permanence plans are in place by the second review, which makes it difficult to monitor performance in this area. The senior management team is aware of this legacy and has plans to introduce a measure in the care planning panel that monitors and quality assures all key care planning points.

72. Adopter assessments are sound, with good consideration given to strengths and potential vulnerabilities. This supports and informs the matching process. Child permanence reports are detailed and identify all of a child's known needs, with the rationale as to why adoption is the preferred option set out clearly. The child's needs and the prospective adopters' ability to meet those needs are articulated well in matching documents. An effective plan to support any identified vulnerabilities is included. Consideration is given to siblings remaining

together and the rationale for decisions about this is based on assessments carried out by those with sufficient expertise.

73. Good efforts are made to ensure that contact is maintained with siblings where this is in the child's interests. Letterbox contact is supported by the local authority and advice is offered to both birth and adoptive families about appropriate content. Letterbox contact is encouraged with wider birth family members where this is appropriate.

74. The chair of the adoption panel is suitably independent. The panel is made up of experienced professionals and adoptive parents. Discussions held by the panel demonstrate probing questioning and robust exploration of relevant issues. The agency adviser provides effective quality assurance to ensure that only good quality work is presented to the panel. The panel demonstrates a positive impact on practice, for example the introduction of a more robust format for connected persons assessments. The agency decision-maker provides prompt scrutiny of panel recommendations and ensures that children are appropriately matched with a family that will meet their needs.

75. Families are able to access effective post-adoption support. There have been no disruptions of adoption placements prior to the adoption order being made for the last six years. The Adoption Support Steering Group is effective in encouraging organisations within Brighton and Hove to be 'attachment aware'. The implementation of an adoption 'passport' that details the offer from organisations across the city is an impressive recent development that provides easy access and support for families at a universal level.

76. Families report that post-adoption support has improved recently. An effective three-tier system works well so that families access a range of universal or targeted services through to a comprehensive post-adoption support assessment. Twenty-four post-adoption support plans were completed in 2014–15 and a further 18 assessments are in progress. Many more families access support at tiers one and two. This support includes an active toddler group, a group for LGBT parents, workshops and training.

77. A commissioned evidence-based training programme for adoptive parents is offered at tier two. It is well received by workers and families, with 38 adoptive families benefiting from the programme over the last year. Additionally, families can access the services of a psychotherapist if they are experiencing complex family difficulties.

78. The virtual school takes a strong, proactive role and provides good support to all children who have been adopted, as well as those who are subject to a special guardianship order. Schools are encouraged to be proactive in identifying adopted children so that the pupil premium can be used appropriately to support them. An easily accessible helpline for schools and adopters provides valued support to adopted children who are having difficulties in school. The local authority has identified that adopted children and

those on special guardianship orders underachieve in school. As a result, the steering group is successfully encouraging schools to use a PEP style review tool to ensure that adopted children's achievement improves.

79. Children are effectively prepared for adoption with careful planning of the introduction process. Children's wishes and feelings are comprehensively considered and sensitive life story work is undertaken. A range of direct work tools is used to assist children to understand the process and develop a secure attachment with their new parents. Children are given a well set out, child-friendly plan and a 'narrative' that details their journey into care and to adoption. They also receive good quality, honestly written later-life letters to help them fully understand the circumstances leading to their adoption as they get older.

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

80. Personal advisers are tenacious in their support for care leavers aged over 18 as well as those who leave care before their 18th birthday. Effective joint working between social workers for children looked after and personal advisers promotes positive transitions to adulthood for looked after young people aged 16 to 18, including those with moderate levels of learning disability. Transition arrangements for care leavers are good and clearly set out, including those for young people with profound disabilities or complex needs.

81. The local authority demonstrates a strong commitment to supporting young people in their transition to adulthood, with the percentage of young people who remain looked after until their 18th birthday higher, at 78% in March 2014, compared with other similar areas and the England average. This is further evidenced by the number of care leavers who remain living with their foster carers under 'staying put' arrangements, with 39 young people (22%) currently in such arrangements. The option of staying put is actively encouraged for all young people as part of pathway planning at the age of 16 and a half. The local authority also provides continuing support to young people who remain in education post-18 who were subject to special guardianship orders or child arrangement orders. Currently, 13 young people aged over 18 are being supported in such arrangements.

82. Personal advisers know young people well, visit them regularly and are committed to staying in touch with them. As a result there was only one care leaver that the local authority was not in touch with at the time of the inspection. Care leavers report that they value this support.

83. Care leavers report that they feel safe in their communities and in their accommodation. They are supported effectively to access safe housing, with 91% of care leavers aged 19 to 21 living in suitable accommodation. The

detailed joint protocol between children's social care and housing services ensures that the accommodation needs of care leavers are met. Care leavers are assisted to apply for a range of supported housing from both local authority and voluntary sector providers. A shortfall in the capacity of supported accommodation means that some young people wait too long to get the most appropriate accommodation to meet their needs. The local authority is aware of this and has already started the process of commissioning appropriate services, such as a new supported lodgings scheme.

84. Overall the quality of pathway plans varies from requiring improvement to good. Some lack specificity and sufficient emphasis on timescales to achieve objectives such as the development of independent living skills. Where plans and reviews require improvement, evidence of managerial oversight is not sufficiently robust. Senior managers identified the issue prior to the inspection and measures are now in place to quality assure and sign off pathway plans and reviews on a regular basis. Risk to young people is identified and assessed well, including the risk of sexual exploitation and going missing. These assessments, however, are not integrated into the young person's pathway plan. Young people's views are well represented within pathway plans and reviews.

85. Issues of diversity, such as ethnicity, faith and sexual orientation, are sensitively considered and inform assessments and plans. Good examples include careful consideration being given to appropriate placement matches in order to support young people's cultural and religious beliefs.

86. The majority of care leavers are supported effectively to develop skills to prepare them for independence. A range of approaches is used, including individual one-to-one support from personal advisers and independence living skills training provided in supported accommodation. In addition, the accredited independent living skills scheme is offered to all young people and is a pre-requisite for supporting a young person's transition to independent accommodation after a period in supported living. Ten care leavers have completed this course in the last six months.

87. The local authority is committed to preventing homelessness for young people. This is achieved by strong partnership working between children's services, housing and the youth service, where young people's needs are central to decision-making. A good joint protocol places emphasis on a proactive approach to preventing homelessness and care leavers are encouraged to access supported accommodation before moving to independent living. In those situations where it is assessed that the most suitable option for a care leaver is independent living, general needs housing is applied for and those young people are given the highest level of allocation priority.

88. In the event of homelessness, the use of bed and breakfast is avoided for care leavers wherever possible. In the last six-month period, no care leaver has been placed in bed and breakfast accommodation. In exceptional circumstances

when bed and breakfast accommodation is used in an emergency, an immediate referral to the youth advice centre tenancy support team ensures that such placements are subject to risk assessment and prompt action is taken to identify a suitable alternative.

89. The health needs of care leavers are effectively responded to and they are supported to register with universal health services. A specialist nurse located within the support through care team undertakes all review health assessments for young people aged 16 to 18. This enables the nurse to build a trusting relationship with young people that helps them to be more confident in engaging with mainstream health services once they are over 18. Although dedicated to the 16 to 18 years age group, the specialist nurse provides advice and support to any care leaver to help them access a range of services, including sexual health, substance misuse and mental health.

90. The quality of the care leaver's health passport, developed by the specialist nurse and a care leaver, is very good. It provides an individualised record of medical history for young people as well as being a young-person-centred resource and access guide for health services. This health passport is currently being rolled out to all care leavers following a positively received 2014 pilot scheme.

91. The local authority currently provides well-planned support to eight care leavers who are pregnant and 27 who are parents. These young people access an appropriate and wide range of universal services in the community, in addition to specialist health visiting support through the family nurse partnership.

92. The local authority has high aspirations for its care leavers. Personal advisers, social workers and specialist staff provide consistently good support over time to support their career aspirations. When current circumstances, such as early parenthood, prevent young people from taking up further training or employment, their long-term needs are considered and planned for effectively.

93. Good performance is evidenced in the rate of those aged over 19 in education, employment and training. Performance for this age group in 2013–14 was 65%, a much higher proportion than in similar areas and in England overall. For the year 2014–15, local data demonstrate that good performance is being maintained. The local authority has a range of good initiatives that support care leavers in their job-seeking journey, including a partnership with the Department for Work and Pensions and Brighton Job Centre. Further, the authority's investment in two dedicated posts in the support through care team and the Youth Employability Service ensures that effective, well-targeted support is provided to young people who are not in education, employment and training.

94. The virtual school's development of a post-16 personal opportunity plan effectively supports young people aged 16 plus to plan their next steps in education, training or employment. The virtual school strongly promotes

university as an option for care leavers by arranging visits with young people as well as undertaking awareness-raising with foster carers. The local authority ensures that young people attending university get good financial support while they are students. There are currently 17 young people at university and a further five planning to attend at the start of the next academic year.

95. An active apprenticeships programme within the council has led to care leavers successfully completing work placements in environmental health, the international team, legal services and parks. Good outcomes are demonstrated by examples such as one care leaver securing a full-time position after successfully completing a three-year carpentry apprenticeship with a local company. Another has completed an apprenticeship with the advocacy service. However, too few care leavers currently benefit from such placements, with only four care leavers in apprenticeships across the city.

96. The council ensures that care leavers' involvement and participation within the council is good. Care leavers influence service delivery and development; they are involved in the CiCC, the corporate parenting board and member training. Their views have shaped the development of the leaving care assessment, pathway plans, the health passport and the pledge 'Leaving Care Promises and Aims' and a range of other material such as financial support leaflets and guidance. As a result, young people are helped to make a successful transition to adulthood by clear information about their history and their entitlements.

97. The local authority is proactive in seeking the views of their care leavers through a wide range of activities that include 60-second surveys, questionnaires and moving on from care interviews. These are used effectively to inform and shape service developments as well as providing a forum for young people's views to be heard and responded to. A good example is the 'Ask Report Change Programme', where care leavers are involved in the inspection of the quality of children's homes and independent fostering agencies commissioned by the local authority. The Young Ambassadors Programme provides another example, where young people are involved in recruitment and have been involved in interviewing for key posts. Care leavers value these approaches and their achievements are celebrated through a range of initiatives including an annual awards ceremony. The authority's commitment to taking account of and learning from their care leavers is further evidenced by the employment of two care leavers into key posts (resource officer and participation worker). These young people provide inspiration for care leavers and their engagement with other young people across the city ensures that the experiences of young people in care and care leavers are understood and that their voices are heard.

Leadership, management and governance

Key judgement	Judgement grade
Leadership, management and governance	Good

Summary

Senior leaders have planned, and are implementing, an ambitious programme of cultural change and improved practice standards. Their priorities are to make changes sustainable and to have a skilled workforce delivering good quality services to children and families. Elected members are equally ambitious, and support the plan led by the Executive Director of Children's Services. Political leaders and senior officers understand their roles and have a clear line of sight to the frontline. Commitment to vulnerable children at all levels is high. Elected members exercise appropriate scrutiny and use their influence well. Participation and user engagement are key strengths, with the involvement of children and young people genuinely sought, achieved and valued. Leaders are active corporate parents.

Effective strategic partnership working is demonstrated by the MASH and is delivering prompt and appropriate responses to referrals. The early help hub is further evidence of strategic vision coming to fruition and benefiting families. Senior managers and their partners work well together, making best use of combined skills to identify and protect those at risk of child sexual exploitation and radicalisation.

Workforce development is a significant priority and a well planned and resourced offer of training supports the planned cultural change. Training is linked to learning from serious case reviews and also to strengthen the new model of practice that is at an advanced stage of planning.

Looked after children live in homes where their needs are being met. Leaders take good account of what is important to looked after children and young people, and are strong and proud corporate parents. Appropriate steps are being taken to improve the stability of relationships between looked after children and their social workers and to sharpen the focus on permanence planning for children of all ages. Work is underway to recruit more local foster carers for the most challenging young people. Local leaders demonstrate success in securing permanence for high numbers of children through adoption and special guardianship orders. Ambition for care leavers is high and the support and care these young people receive ensures that they feel safe where they live and that they make good progress in their lives.

Vulnerable children do not yet receive a consistently good service. However, leaders and managers now use performance and quality assurance processes effectively and as a result have already identified all the key areas where practice needs to improve.

Inspection findings

98. Creating the right culture and environment for sustainable change is a firm priority for the current senior leadership team and the journey towards being good in all areas has been steady but decisive for the past 12 months. Prior to the appointments of the present Chief Executive, Executive Director of Children's Services and Assistant Director Social Care, the senior leadership team lacked stability. This has meant legacy issues within services that were weak or poorly coordinated have made sustained improvement difficult to achieve. Current directorate and team plans clearly identify improvements that are still needed.

99. Ambition is high but realistic, and sustainable changes are being made. For example, the introduction of the MASH has improved the coordination and speed of the first response to vulnerable families. The strategic vision for early help is now clear and the coordination of services at this level has been enhanced by the implementation of the early help hub. The IRO service, which historically did not have sufficient capacity to deliver all its core functions, has been strengthened and contributes effectively to raising standards.

100. Leaders are outward-looking and are learning from other organisations in their thinking about models of practice and new ways of working. Through the pilot 'teaching partnership', stronger links are being forged with local universities in order to improve the preparation and experience of social work students. The 'transformation of social work' programme has been informed by the careful consideration of models of practice in other areas. Commitment to improving long-term outcomes is exemplified by 'Looking Forward', a programme to help mothers who have had children removed and adopted to plan and care for subsequent children.

101. The Health and Wellbeing Board is a well-functioning group with a helpful balance between partners and political leaders. Priorities are appropriately focused on vulnerable children and are aligned to those of the local authority. Key leaders are well engaged, including the LSCB chair. The board is taking appropriate steps to understand key local and national issues such as child sexual exploitation.

102. Elected members from the three parties who hold political power are well informed and exercise appropriate scrutiny through the Children and Young People's Committee, the Health and Wellbeing Board and the Child Review Board. Service and performance information is shared and analysed, enabling members to maintain a good understanding of the delivery of services to local families. Members have been well briefed about key issues such as child sexual exploitation and radicalisation. The Chief Executive chairs 'One Voice', a group that brings together a range of ethnic and faith communities to raise and address issues of prejudice, extremism and inequality.

103. Political leaders and senior officers and the chair of the LSCB work together well, with regular informal and formal meetings and detailed discussion about key issues such as findings from multi-agency audits. The Chief Executive and lead member are well engaged with staff, local services and young people. The lead member is an active member of the LSCB, Corporate Parenting Board and the adoption panel, and regularly attends the Health and Wellbeing Board.

104. In some areas, sufficient improvement has not yet been achieved, for example in the consistency of response to children who go missing from home. A peer review, undertaken in November 2014, identified some key areas for improvement in missing from home practice. The local authority understands its weaknesses in this area and an action plan is in place to address them.

105. Further improvement is also needed in the length of time it takes for social workers to complete single assessments. Additional staff have been appointed to meet the demands created by high and rising referral rates. Management information is increasingly being used to track and oversee these assessments and there is a drive to improve timescales without compromising quality. Timescales are gradually improving.

106. Commissioning activity is undergoing positive and considerable change. All services above £75,000 are being re-commissioned in line with a new overarching commissioning strategy. New arrangements ensure that the clinical commissioning group is more actively engaged. The approach to commissioning and de-commissioning of services is increasingly analytical, with a range of data and evaluative information including the joint strategic needs assessment being used to inform decision-making.

107. A creative but at times reactive approach to commissioning has led to a high number of diverse in-house and externally commissioned services across the city. Such services are effective in helping families and are much valued by them. A strong commitment to youth work has led to the re-shaping of services and now includes the Youth Employability Service (previously Connexions). These services are in high demand and are central to the offer of help to local teenagers, including those who are experiencing instability in their families or their communities. Commissioned services are evaluated, but the wider impact on children, young people and families is not consistently understood, particularly in relation to key strategic priorities.

108. The sufficiency strategy is up to date, clear and coherent, with appropriate priorities linked to present and future need. Steps are being taken to address gaps, for example through the commissioning of an independent company to increase the number of in-house foster carers for older and more challenging young people. The 'payment by results' element of this arrangement demonstrates a commitment to achieving value for money.

109. The performance framework is well embedded and the quarterly performance board rigorously analyses key performance indicators, progress against

performance targets, risk actions, learning from complaints and audits and key people data. Helpful context and commentary is included. Managers are held to account for poor performance and the move to a culture of continual improvement is well underway. Management information is accessible, helpful and comprehensive, although not all managers at all levels use it consistently or effectively. Additional resource has been invested to help managers understand, interpret and use this data more effectively.

110. The quality assurance framework is well established, with learning routinely identified and disseminated from a range of sources including complaints and regular themed and deep-dive audits. The Executive Director of Children's Services and the lead member have undertaken auditing as part of this process. The audits undertaken by the local authority for this inspection were analytical and appropriately challenging. The local authority has a clear understanding of what good and poor practice look like.

111. Members of the corporate parenting panel demonstrate a sound understanding of the key issues facing looked after children and care leavers. The board is well attended by looked after children and care leavers, council members from all parties, foster carers, the virtual school and the clinical commissioning group. It is focusing on the right things, considering key issues such as education and health systematically and in detail, while also ensuring that looked after children can bring the issues that are most important to them (such as pocket money).

112. The appointment of a graphic designer and participation worker with Brighton and Hove care experience has led to the creation of high quality young-people-friendly documents such as the council's pledge to children in care, and has increased the reach and depth of engagement. These young adults care deeply about their work. Their involvement in the corporate parenting board has strengthened the voice of young people in this process and is bringing about meaningful change.

113. The local authority responds to complaints in a well-organised and open way. Where it identifies wider practice issues, it takes steps to introduce and embed the necessary changes. A series of complaints from parents who do not live with their children has led to new practice guidance for staff. It includes helpful information about parental responsibility and clear expectations for how these parents should be engaged with processes such as child protection conferences. In cases seen by inspectors, the engagement of parents within these families is increasingly effective. The Executive Director of Children's Services takes an active interest in complaints and uses this to increase his knowledge of what is happening within key social work teams.

114. Participation and user engagement is strong, with the involvement of children and young people genuinely sought, achieved and valued. For example, during 2014, 12 young people completed accredited interview training. A total of 17 young ambassadors were actively engaged in the programme and participated

in interviews for 13 key posts such as the head of the virtual school, the assistant director and LSCB lay members. The Children's Services Participation and Engagement Strategy has been developed with the involvement of young people, staff and a multi-agency working group including public health and representatives from the community and voluntary sector. It demonstrates that the local authority is committed to protecting and further strengthening this area of already good practice.

115. The children's services workforce is relatively stable, sickness rates are improving and the use of agency workers low. Social workers and other practitioners care about their work with children and families and about the council. Caseloads are manageable overall and staff feel well supported by their teams and their managers. The vision for the new model of practice is coherent, with the right balance of care for social workers, relationships with families and performance management. It is being introduced in a measured way through constructive engagement with staff.

116. Decision-making, supervision and management grip at team level are not consistently rigorous. In too many cases, this is delaying desired improvement. Senior managers are aware of this through regular case auditing and the new model of practice has been designed to address this. Within tracked cases, where management oversight has been poor, there is evidence of recent improvement leading to plans being back on track and progressed. It is crucial that inconsistencies in management oversight and case supervision are addressed effectively if services for children who need help and protection are to be good.

117. The Assessed and Supported Year of Employment (ASYE) programme for social workers is well established, with 123 newly qualified social workers (NQSWs) being supported in the last five years. Support to the current cohort of 22 is coordinated by an experienced social care manager who confidently oversees and mentors her virtual team. Some of these NQSWs have previously experienced support and care that is less than good, with insufficient supervision or high caseloads. The ASYE manager has acted swiftly to improve their experience.

118. Although currently filled by an interim post-holder while a permanent appointment is made, the principal social worker (PSW) role is well established and at an appropriate level to have influence and reach. There are effective links with regional PSWs for sharing good practice and joint initiatives.

119. The training offer is comprehensive and staff working with families at all levels of need are well supported to attend training events. However, social workers are not always able to talk confidently about how they assess the impact of neglect within families and the training offer for staff who are making important judgements and decisions about risk in this area needs to be strengthened.

120. There have been three serious incident notifications to Ofsted in the last two years, two of which have led to the commissioning of serious case reviews. Neither has yet been concluded. While awaiting the findings of formal case reviews, the local authority is taking appropriate steps to care for staff alongside acting on any immediate learning.

121. The local authority has a strong strategic and operational partnership with local schools. Through a schools safeguarding audit in 2014 it has maintained a good understanding of each school's safeguarding profile. This informs developments such as anti-bullying strategies and has enabled targeted support to be provided, for example in supporting schools to help pupils with emerging self-harming behaviour.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is good
The arrangements in place to evaluate the effectiveness of what is done by the authority and board partners to safeguard and promote the welfare of children are good.

Executive summary

The LSCB has rapidly developed over the last two years from a local-authority-dominated board to a transparent, learning-focused multi-agency LSCB. The LSCB effectively monitors and influences improvements in frontline multi-agency safeguarding practice.

The LSCB undertakes its statutory responsibilities carefully and thoroughly. Its members recognise that not all elements of multi-agency safeguarding practice are yet of a consistently good standard, but there is a clear understanding of where further improvements are required. For example, the LSCB is aware of gaps in service responses to children who go missing. It has provided suitable challenge but has not yet been assured that the necessary improvements are in place.

The LSCB should build a better understanding of the effectiveness of early help services. Additionally, the board should further scrutinise numbers of repeat referrals and child protection plans.

The LSCB routinely scrutinises data in relation to children becoming looked after, although it needs to give more focus to looked after children living outside the authority area and improve its understanding of why thresholds for care or accommodation are reached.

The LSCB has strong leadership and effective governance arrangements, featuring senior managers from partner agencies chairing the majority of its sub-groups. The board now has a strong multi-agency influence and expertise for its oversight and evaluation of practice, providing an increasingly informed and diverse picture of particularly vulnerable groups of children and young people in the city.

The LSCB is outward-looking and ambitious to accelerate its momentum and influence as an improvement and change agency in the city. It has a strong presence in schools, the voluntary and private sector and in the city's health economy. The LSCB is demonstrably open to the suggestions and challenge of lay members and imaginatively seeks out feedback from children and young people on both how safe they feel and how the LSCB can incorporate their ideas in influencing its priorities and service development.

Recommendations

122. The LSCB should collate and analyse information from missing return interviews to improve knowledge of any common locations, trends and patterns.

123. The LSCB should build a better understanding of the effectiveness of early help assessments and interventions to ensure that children and young people with additional needs receive timely responses and that emerging difficulties are addressed at an early stage.

124. The LSCB should continue to scrutinise and influence the reduction of both the high number of repeat referrals and child protection plans, ensuring that partnership agencies understand and apply the local threshold criteria.

125. The LSCB should improve its links with the corporate parenting panel to provide greater focus to looked after children living outside the authority area and to better understand why thresholds for care or accommodation are reached.

Inspection findings

126. The LSCB has revised its governance arrangements to clarify and improve the rigour and accountability of its sub-structure and leadership group. An LSCB constitution and compact underpins the new arrangements, strengthening the responsibilities of partner engagement in, for example, multi-agency audit programmes and their attendance at LSCB meetings. Concurrently, the LSCB, led by the chair, has successfully delivered cultural reform from a predominantly process-focused, local-authority-led board to an outcome-based, multi-agency forum where partners routinely interrogate and challenge performance information.

127. LSCB members across the range of partner agencies welcome the positive cultural shift. This enables the board to identify and share cross-cutting intelligence and knowledge about particularly vulnerable groups of children and young people and to develop appropriate strategies and actions. Recent examples include stronger responses to radicalisation and the earlier identification of young people exposed to the risks of child sexual exploitation.

128. The chair has constructive relationships with other key strategic boards, both influencing their plans and holding them to account. Recent collaboration with the Health & Wellbeing Board contributed to the decision to review CAMHS and the emotional health and well-being services in the city. This arose from a learning review regarding a young person with self-harming behaviours.

129. The involvement of the Chief Executive and Director of Children's services is integral to the board's effective functioning. For example, they led a multi-agency section 11 challenge event in 2014 to rigorously test the compliance of partner agencies with core safeguarding policies and to increase levels of

engagement with the safeguarding agenda. A good example is the additional funding secured by the clinical commissioning group for a specific post to work with general practitioners to improve their identification and responses to domestic abuse as a consequence of an LSCB multi-agency audit on domestic violence and abuse.

130. The LSCB business plan focuses strongly on improving fundamental indicators of effective safeguarding including child sexual abuse and exploitation. The plan also considers how well children and young people participate and engage with services they are involved with. The LSCB has a well-considered three-year business planning cycle to achieve sustained improvements in an appropriate set of priorities. Measures of progress via multi-agency audits are included. The business plan does not provide a focus on children looked after living outside the local area and this is a shortfall. It is regularly reviewed at full board meetings and at leadership group meetings. The chair is aware that the board should be steadily focused on its core priorities.

131. The LSCB has a good quality assurance framework, supported by a complementary learning and improvement framework. This means that a planned approach is in place to measure the effectiveness of key safeguarding priorities. The monitoring and evaluation sub-committee leads on the design, implementation and reporting of planned multi-agency audits. Four good quality audits were undertaken in 2014, highlighting for example drift in some child in need plans and the lack of consistently robust and reflective supervision. Audit recommendations are rigorously pursued and repeat audits are scheduled to test whether improvements are sustained.

132. The LSCB has made tenacious efforts to develop a multi-agency performance management framework by adding relevant qualitative information to its core performance data, for example from the findings of single- and multi-agency audits. Contributing agencies provide commentaries explaining data trends and variances. The LSCB recognises that further refinement of performance information will be a gradual process and is working purposefully to increase the range and impact of its multi-agency intelligence.

133. The LSCB has a rigorous approach to evaluating the effectiveness of safeguarding arrangements in all of its partner, community and voluntary agencies. Compliance with safeguarding procedures and policies is widespread and analysis identifies themes for further development including, for example, improved work with fathers and male partners and better supervision of safeguarding leads. A safeguarding audit in schools achieved an excellent 100% rate of return. Findings identify that a large majority of primary and secondary school pupils in the city feel safe in their schools. Only a small minority of schools are identified as needing to take action to improve their safeguarding policies and procedures.

134. A comprehensive learning and improvement framework is strongly aligned with the multi-agency audit programme. The framework is informed by intelligence

from section 11 audits, agency annual reports, audit findings and the recommendations of serious case reviews and learning reviews. The LSCB Monitoring and Evaluation Subcommittee considers the 12 multi-agency child protection and children in need cases audited each quarter by the local authority, alongside themed audits targeted in the annual programme. Audit findings and recommendations are systematically and comprehensively disseminated across the partnership. The intelligence from completed audits, serious case reviews and learning reviews is used effectively to inform the content of specialist multi-agency training programmes, achieving a circular, joined-up model of learning and improvement.

135. Serious case reviews are commissioned in accordance with statutory criteria and thresholds applied correctly. The LSCB has adopted the Social Care Institute for Excellence methodology for undertaking both serious case reviews and learning reviews to better understand agency actions and effectively identify key learning outcomes. This leads to targeted and achievable action plans. The implementation of action plans is closely monitored. Learning review action plans receive the same level of scrutiny and attention as serious case reviews. Two serious case reviews have recently been commissioned and are in preparation, one has been recently completed and another is near to conclusion. Four learning reviews and two single agency reviews have been completed recently. Learning from reviews is appropriately cascaded to the workforce through a series of events for practitioners and frontline managers as well as through e-newsletters, e-bulletins and through LSCB members themselves.

136. The Child Death Overview Panel is effective in scrutinising serious incident notifications and has strong links with the serious case review sub-group. The panel has identified a small number of modifiable factors in reported child deaths, largely concerning co-sleeping arrangements for infants. The panel has also improved communication protocols between specialist tertiary hospital trusts and the local health system following the death of a young person with a complex health condition. This illustrates the panel's capacity to identify and achieve safeguarding improvements in other strategic bodies.

137. The LSCB's influence was instrumental in the formation of the MASH, the most recent threshold document and the development of the early help hub. The board is satisfied that all families that are referred are offered early help assessments and interventions at the weekly allocations meeting. The board has a multi-agency audit of early help and thresholds scheduled for September 2015, a year following the implementation of the early help hub. This audit is planned to evaluate overall effectiveness and is not in response to any concerns about thresholds.

138. An effective child sexual exploitation strategy and action plan is in place. A strategic sub-committee and two operational sub-groups are addressing child sexual exploitation through improved identification of potential victims. In addition, protection of victims is robust and prosecutions and disruption are

pursued with determination by partner agencies. A recent multi-agency audit observed that effective identification of risk factors concerning boys and young men are underdeveloped. The LSCB has achievable plans to improve the identification of children and young people at risk of child sexual exploitation at earlier stages, and their prevention and early identification sub-group is well positioned to progress this.

139. The LSCB has anticipated that numbers of identified victims will expand and is accordingly preparing to survey and challenge agencies about how they intend to meet this increasing demand. The WiSE (What is Sexual Exploitation) Project in the city recently undertook an intensive outreach awareness-raising exercise with young people and venue managers and staff, visiting bars and clubs across the city's night-time economy. This endeavour demonstrates the effectiveness of the LSCB's wide-ranging approach to addressing child sexual exploitation in the city.

140. The LSCB thoroughly evaluates intelligence and cross-cutting themes regarding particular groups of vulnerable children through an overarching vulnerable children's sub-group. The group considers the effectiveness of multi-agency responses to young people affected by, for example, forced marriage, modern slavery, radicalisation, female genital mutilation and other specific vulnerabilities. The sub-group has enlisted the services of a national charity and the lesbian, gay, bisexual and transgender lead from Community Safety to assist in identifying young gay men who may be at risk of sexual exploitation through, for example, visiting a local public sex site. The board has an appropriate action plan to further scrutinise and understand the effectiveness of services delivering return-from-missing interviews.

141. The LSCB's child protection liaison group identifies, through the presentation of case examples, difficulties in multi-agency frontline practice that require a swift multi-agency response. This arrangement enhances the capacity of senior partnership managers to achieve timely improvements within the safeguarding system. Recent examples have included improving the content of GP reports to child protection conferences and an improved risk assessment pathway for non-mobile babies who present with injuries.

142. Local multi-agency safeguarding procedures are well coordinated by the Pan-Sussex Procedures Group. Updates are quickly inserted and disseminated, including specific local additions. A recent example was the development of procedures regarding radicalisation that are particular to Brighton and Hove. The procedures are easily navigable on the LSCB website platform. Informal feedback indicates that staff find the procedures a valuable resource; a formal survey of compliance will be undertaken later this year.

143. The LSCB is an active and influential participant in informing and planning services for children and young people. Prominent examples include an effective challenge made to NHS England following the unexpected closure of a general practice in one of the most deprived parts of the city. The LSCB chair

has been influential in attaining the inclusion of safeguarding content in the Health and Wellbeing Strategy and also in assisting the scoping of the Safeguarding Adults Board's duty to ensure effective transitions for vulnerable young people into adult services, using evidence from case reviews to highlight gaps.

144. The LSCB multi-agency annual training programme ensures that training content is carefully designed to deliver specialist courses that complement learning priorities in the business plan and the learning and improvement framework. Practitioners are aware of the LSCB training offer and many spoken to have recently attended training. Staffing difficulties have impeded plans to improve post-course evaluations and the impact of training on improved practice. The LSCB is ambitious to recover progress following the imminent recruitment of a new training manager. The poor attendance of some agencies at core LSCB safeguarding courses has been challenged by the chair.

145. The board has made meaningful progress with effective and innovative initiatives to improve the engagement of children, young people and their families and also to increase public understanding of the board's work. Prominent among these is an accessible, informative and interactive website featuring Twitter, allowing LSCB members and the chair to have a wide range of ongoing exchanges with the board's audiences. Followers include parent groups, schools and teachers.

146. The good quality LSCB annual report reflects the board's learning and self-evaluative ethos. Priorities requiring further attention are highlighted, such as the provision of better performance information from some partner agencies and improving the content of referrals to the LADO. The effectiveness of local services are appropriately reported in summaries of completed multi-agency audits.

Information about this inspection

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

Inspectors considered the quality of work and the difference adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people 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 eight of Her Majesty's Inspectors (HMI) from Ofsted.

The inspection team

Lead inspector: Lynn Radley

Deputy lead inspector: Stephanie Murray

Team inspectors: Pietro Battista, Pauline Turner, Donna Marriott, Nick Stacey, Anji Parker and Jon Bowman

Quality assurance manager: Nicholas McMullen

Any complaints about the inspection or the report should be made following the procedures set out in the guidance *Raising concerns and making complaints about Ofsted*, which is available from Ofsted's website: www.ofsted.gov.uk. If you would like Ofsted to send you a copy of the guidance, please telephone 0300123 4234, or email enquiries@ofsted.gov.uk.

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, workbased learning and skills training, adult and community learning, and education and training in prisons and other secure establishments. It inspects services for looked after children 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 4234, or email enquiries@ofsted.gov.uk.

To receive regular email alerts about new publications please visit our website and go to 'Subscribe'.

Piccadilly Gate
Store St
Manchester
M1 2WD
T: 0300 123 4234
Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
W: www.ofsted.gov.uk