An investigation into the whistleblowing complaint within children's social care services in Southampton City Council.

Learning report[1]

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July 2020

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1. Introduction

1.1. On 27 January 2020, a collective grievance was submitted by the Unite branch secretary on behalf of 31 managers and staff alleging dangerous practices, unsafe decision making and a hostile work environment in children's services[2] created by senior managers in the directorate. The council commissioned Malcolm Newsam, on 10 February, to undertake an independent investigation into these complaints. The grievance has been considered under the council's whistleblowing procedure and was completed in May 2020.

1.2. I have clustered the complaints into the following six themes.

- The service is failing to keep children safe due to poor and dangerous decision making
- Management issues related to failing to keep children safe
- Deliberately misleading the regulator Ofsted
- The use of agency workers and consultants.
- A culture of fear has been allowed to grow in children's services.
- Creating a loss of trust and confidence in Southampton City Council by partner agencies

1.3. My investigation comprised the following:

- I have interviewed the Unite branch secretary and 25 current and previous employees of the council. Ten of these individuals had contributed to the collective grievance and 15 of them had not. The latter group were in the main selected by me on a random basis, others had been recommended by the human resources department in the council. I was assisted in my investigation by a member of the council's audit team who kept a record of these interviews
- The original complaint set out ten case examples, to illustrate the allegation of unsafe practice. I have been provided with evidence to review seven of these cases. During the investigation managers provided me with the names of additional cases which they believed exemplified the concerns within the complaint. I have been able to review 21 cases in total using the council's case record system, Paris.
- I have also undertaken a review of all the available contemporaneous documentation between senior managers in the service and staff including

[2] While the grievance refers to *all teams in Children's Services* the complaint was limited to children's social care services and did not include those teams working within the education function.

communications and emails and also the policies of the council, relevant to this investigation.

1.4. I provided a full report of my investigations and conclusions to the council in May 2020. This report comprised 120 pages in total and includes the detailed analysis of my findings. Both the whistle-blowing complaint and my report are confidential to protect the anonymity of the whistle-blowers and the employment rights of staff and managers concerned. Since the receipt of the whistle-blowing complaint and my report, the council has made significant changes to the senior leadership team of the service and has recently appointed a new executive director of children's services. This summary report is to support the leadership team in responding to the findings within my investigation.

2. Key Findings

Complaint: The service is failing to keep children safe due to poor and dangerous decision making

2.1. In November 2019, Ofsted undertook a full inspection of children's social care services and judged that the service required improvement to be good. I have been informed by the council that the inspectors considered over 300 cases during this inspection. Inspectors concluded that the overall quality of social work for children who are the subjects of statutory plans and who are looked after by the council was not consistently effective. Inspectors also alerted managers to a small number of children who had not been adequately safeguarded. The cases I considered were limited to those drawn to my attention by the whistle blowers. Nonetheless, I believe my findings are in line with the judgements made by Ofsted a few months earlier.

2.2. I reviewed 21 cases. I upheld the complaint in 13 cases. During my investigation I did not come across any cases where a child was immediately at risk although on receipt of the whistle-blowing complaint the deputy chief executive did make the decision to bring a young person into care given concerns for her immediate safety.

2.3. In defence of the senior managers concerned, they will have been making many decisions on a day to day basis and these will often relate to giving the permission or otherwise to accommodate children. Not surprisingly, some of these decisions might not have been popular with staff and may even, with the benefit of hindsight, have been questionable. However, the complaints I upheld were of a substantially different order:

- Examples of senior managers within the service unilaterally over-riding the collective planning arrangements that are in place to ensure that decisions are

taken in the best interests of the child. It is unusual in my experience for this to occur and when it does, it is important that senior managers broker this with the professionals concerned. In many of these instances the decision-makers ignored the best advice of multi-agency meetings designed to ensure that children are kept safe, and in this regard, they potentially placed a significant amount of risk upon themselves and the council.

- Secondly, no-one I spoke to in my investigation, disputed the legitimate desire to keep children safely out of care and to manage budgets prudently. However, in the complaints I upheld, the alternatives, often globally referred to as "wrap around support" were either not available or not suitable to the situation in which it was being applied.
- Thirdly, there is evidence that, on occasions, in the struggle to ensure children remained with their parents, the needs of those very children were lost sight of.

I therefore upheld this aspect of the grievance.

Complaint: Management Issues related to failing to keep children safe

2.4. The grievance asserted that that senior managers in the service deliberately did not record their decisions on Paris. However, I was not provided with any substantial evidence to support this. There is ample evidence of decisions being set out within emails and it would be a reasonable expectation for the responsible worker/manager to upload these on to Paris. I was given one example where a manager was asked to amend the record on Paris but that did not in any way relate to the decision itself. I did not, therefore uphold this complaint.

2.5. However, there is significant evidence that the removal of the peripatetic teams towards the end of the year, did lead to significant numbers of cases being unallocated and/ or the transferring of cases. These were some of the most vulnerable children on caseload and this change did present risks to the service. The ending of the contract with the provider was foreseeable and could have been planned well in advance and the serving of one weeks' notice during the Christmas break could only have compounded the disruption. The replacement of the contract with the "Hub" teams was ill-thought out and poorly communicated. No business case was made to justify this initiative and despite the novel make-up of the teams, no operating procedures were agreed or distributed. The introduction of newly qualified and unqualified staff to undertake work usually undertaken by qualified experienced staff was not something that could be done without a careful risk analysis and formal consultation with staff and trade unions.

Similarly, sourcing these staff from an agency provider was ill-advised and could only lead to an additional cost pressure and a greater reliance on temporary staff. Through my interviews, it has also been made apparent that the regular changes in service size and structure has been a major destabilising characteristic within the service and will have contributed to the sense of chaos many staff have referred to. That these changes appear to have been implemented outside of the authority's human resource policies compounds the issue still further. I, therefore, upheld this complaint.

2.6. The grievance stated that agency workers were instructed to close as many cases as possible, some without undertaking visits or welfare checks on the child. I was not provided with substantial evidence to support this. While several managers have indicated to me that they were aware of some cases being closed in less than ideal circumstances, this was always linked to the pressure within an overwhelmed service. To close any case without an appropriate assessment is dangerous practice and against statutory guidance. However, I have seen no evidence that this was either on the instruction of senior managers within the service or even condoned by them. Quite the contrary, there is clear evidence that senior managers took any evidence of inappropriate closure seriously. I did not therefore uphold this complaint.

Complaint: Deliberately Misleading the Regulator Ofsted

2.7. The grievance stated that Ofsted were deliberately misled to achieve a more positive rating. I have not been provided with substantive evidence to support this. All authorities will organise themselves to present the best possible case to Ofsted and in that regard, Southampton is no different. It is unusual in my experience for a few staff to be asked to work from home to avoid scrutiny by the inspectors, (as was the case in Southampton) but this would have had only a marginal impact on the inspection outcome. I have seen no evidence of cases being closed deliberately to impact on the caseload figures and no evidence of placements ended without assessment. I did not, therefore, uphold this complaint.

2.8. There is no evidence that senior managers in the service were able to mislead Ofsted by withdrawing cases. On the one case drawn to my attention, senior managers acted appropriately. Ofsted ask local authorities to provide cases of good practice. It would be reasonable for senior managers to review them and present those cases that they believed were the most compelling. I, therefore, did not uphold this complaint.

2.9. There is evidence that senior managers in the service appeared to renege on their commitment not to withdraw resources after the Ofsted inspection. It is evident that the assessment teams were reduced from four to three shortly after the Ofsted inspection. Given the difficult history of the service, it is understandable that this would have generated anxiety amongst those managers and staff and should have been carefully managed. The lack of communication about the rationale and operating procedures of the "Hub" teams alongside the termination of the peripatetic team's contracts will only have served to exacerbate these anxieties. I, therefore, upheld this complaint.

2.10. The complaint alleged that senior managers in the directorate were unable to explain why the service had been in chaos for the past four years, but I did not find evidence to support this. The Ofsted report does state that "*senior leaders contend that a significant rise in levels of poverty over a four- year period in more economically deprived wards of the city has been a primary cause of increased referrals through the MASH. However, they have not explained why a reported four-year trend in escalating deprivation triggered such a marked and relatively sudden increase in referrals at a particular point in that cycle*." The explanation by senior managers within the service was not plausible and was recognised as such by Ofsted. However, Ofsted were not considering the impact of the workforce reductions in 2018/19 but the increase in service volumes in 2019/20. At the time of the inspection, the service was running with significantly higher numbers of social workers and the issues referred to by the whistle blowers (merging of MASH, child in need and child protection teams) while painful at the time were not contributing to current service weaknesses. I, therefore, did not uphold this complaint.

2.11. There is evidence that thresholds for receiving statutory social work support changed dramatically and inappropriately in the first few months of 2019 following the interventions of a team of consultants. This led to a significant increase in open cases which overwhelmed the service. The consultants were given significant authority by senior managers to direct the management of cases and there is evidence that they did this often without any explanation. It is hard to understand why this could happen, and it was unlikely to support improvement or learning amongst the staff group who were responsible for the operational running of the service. I, therefore, upheld this complaint.

Complaint: Use of agency workers and consultants.

2.12. I found clear evidence that senior managers within the service did not follow the council's policies and procedures on the appointment of consultants and, therefore, the normal safeguards to protect the council from any allegations of preferential treatment

or the misuse of public money had not been adhered to. It also is the case that there does not appear to have been any scrutiny of the role of external consultants. I have seen examples of consultants who were appointed to undertake one role but then move on to other more operational roles. I, therefore, upheld this complaint

Complaint: A culture of fear has been allowed to grow in children's services.

2.13. The cumulative impact of a service struggling to meet high demand, the approach of a team of external consultants seen to have too much authority, alongside the manner in which two middle managers were suspended created a widespread belief that there was a culture of fear within the department. This view was widely held by the managers I interviewed and was not just limited to the whistle blowers. It has also been previously evidenced by the Appreciative Inquiry. I, therefore, upheld this complaint.

2.14. I have only received anecdotal evidence in respect of the allegation that staff were told they lacked emotional resilience. This was repeated to me by two interviewees. I have not been given any evidence that senior managers within the service prevented or stopped the counselling of staff who felt under pressure. It is also conceivable that the comment could have been misconstrued. I did not, therefore uphold this complaint.

2.15. There is significant evidence to suggest that the service was under-resourced and struggling to manage the influx of new cases in the system. This is supported by the data in the ChAT[3] analysis I have considered. I have received substantial anecdotal evidence from managers that caseloads were unrealistically high, and this was exacerbated by the regular transferring of cases caused by the departure and arrival of successive agency social workers. I have asked to see the monthly management data on unallocated cases and caseload sizes in 2019 but have been informed that no such reports exist. Without the data, I am unable to confirm the degree of the concerns that have been expressed to me. Ofsted who inspected in November 2019 reported: *At the point of the inspection, social workers' caseloads had substantially reduced and were largely manageable. Addressing this challenge has consumed considerable senior management time and diverted their attention from planned improvement work.* This does suggest that caseloads had been unrealistic earlier in the year. Based on the information provided to me, I upheld this complaint.

2.16. There is a widespread belief that the Appreciative Inquiry completed in September 2019 was buried. As the findings of the report and its recommendations were not shared with

[3] Children's services Analysis Tool

the wider management group in the services it is understandable that managers gained this impression. The author of that report found the following:

- An expressed fear of speaking out- this included highlighting errors, challenging tactics, offering a different opinion to some leaders
- The current working environment is chaotic. It was described as a blame culture
- Communication at all levels was considered to be ineffective and uncoordinated
- There was a strong sense of a top down imposition. A high number of the problems and challenges were known about and had been reported however it was considered the front-line staff were not engaged openly or respectfully by some senior leaders
- The style, tone and timeliness of communication from the leadership team or in some instances the lack of it has created resentment confusion and anxiety

2.17. The Appreciative Inquiry made six recommendations five of which are relevant to my investigation

- *People who work in, and with the department, need to feel psychologically safe… Urgent steps need to be taken to change this operating culture.*
- *Positively engage with the broader leadership community. Engaging them in this type of forum will provide the openness for collective problem solving*
- *An immediate reappraisal regarding the number of cases being managed by social workers and newly qualified social workers.*
- *Develop a compelling vision for the future that engages the whole department.*
- *Change the narrative across the department and also externally… creating a sense of hope and optimism.*

2.18. Unfortunately, a summary and the recommendations were not shared with managers and staff within the service. This could have formed the basis of a more collaborative approach going forward. While there was work done with managers on behaviours, the on-going issues of poor communication and service changes without consultation continued after the Appreciative Inquiry, accompanied by a robust and challenging management style from senior leaders in the service. I therefore upheld this complaint.

Creating a loss of trust and confidence in Southampton City Council by partner agencies

2.19. At the commencement of my investigation, I agreed with the chief executive of the council

that it was not at this stage appropriate to extend my investigation to include other agencies, given its confidential nature and the risk of additional reputational damage to both the council and senior managers. I, therefore, have insufficient evidence to come to a view on this aspect of the complaint.

3. Conclusions and Recommendations

3.1. I have upheld a substantial proportion of the specific complaints made within the collective grievance. My findings echo many of the conclusions of the Appreciative Inquiry which reported in September 2019.

3.2. The council has recently put in place a refreshed leadership team within children's services and has recently appointed a new executive director of children's services. This provides an excellent opportunity to take the learning from this investigation and, looking forward, put in place an empowering and inclusive culture that creates an environment which makes Southampton a great place to practice social work. I would suggest the following five recommendations:

Recommendation One: Develop across the council a compelling and ambitious vision which aspires to deliver the best possible outcomes for all children in the city**.**

3.3. This vision should mobilise all council services, alongside the contribution of partners to tackle disadvantage, while investing in all children and young people, to build a successful future. The aspiration should be to deliver good or outstanding children's services. This vision should be underpinned and supported by corporate values which put the well-being and safety of children at the centre of all decision making.

Recommendation Two: Promote an inclusive culture, which connects senior management with practice and ensures that staff concerns are swiftly addressed.

3.4. Senior managers, across the directorate of Children and Learning, need to be in touch with the pressures on the front-line, the practical impediments to delivering effective practice and the impact of their decisions on the quality of practice. This will require a refreshed communications strategy which should include an explicit approach to communicating all significant management decisions, consulting with relevant staff and managers appropriately and building in an opportunity for feedback. This should be supported by a "you said, we did approach" to any major change or development. The executive director of children's services and the Lead Councillor should together undertake a safeguarding assurance visit to one service team a month, reviewing the performance and listening to the experiences of front-line staff. The chief executive with the Leader and Lead Councillor should also hold a bi-annual safeguarding assurance

meeting with the director of children's services where they can be briefed on the successes and pressures in the service and any emerging concerns. In addition, the council should facilitate the setting up of a practitioners' improvement board to support the delivery of the improvement plan and provide a front-line "sense check" on its effectiveness. A representative of the practitioner's improvement board should participate in the council's children's services improvement board.

Recommendation Three: Invest in managers and staff to deliver high quality services for children.

3.5. High quality children's services require staff who are well trained, supported and encouraged in their development. The council must invest in the training and support it provides to existing and aspirant managers in the service and develop a strategy to grow internally, the leaders of the future. A similar investment needs to be made into high quality supervision arrangements which provide both support and challenge to practitioners. The council will need to be assured that managers have sufficient capacity to undertake supervision of the required quality and intensity. Alongside these support arrangements managers must be confident in setting high expectations in respect of the quality of practice through the following:

- Practice standards that all staff and managers understand, and which ensure the best possible outcomes for children
- Effective quality assurance systems which identify where practice is good and where it needs to improve
- A robust performance management system that monitors compliance, volumes and timeliness and the effectiveness of outcomes

Recommendation Four: Introduce a compelling workforce strategy that ensures Southampton is the destination of choice for experienced and capable social workers and managers.

3.6. The council must develop a unique Southampton offer that promotes the recruitment of good social workers while addressing retention and the over dependence on agency staff. This will require highly skilled input from experts in communications and media messaging as well as recruitment and marketing specialists. This should include explicit expectations about manageable workloads, the availability of supervision and flexible working arrangements. It will also require a fundamental re-appraisal of the infrastructure and support requirements for social workers and must include addressing any deficits in the provision of computer equipment, the case management system, business support and accommodation.

Recommendation Five

Ensure the council has a regular independent assessment of the effectiveness of its children's social care services

3.7. The council has in place an improvement board for children's social care, chaired by the executive director of finance and commercialisation and an emerging improvement plan. This now needs to be supplemented by the learning from the Appreciative Inquiry and this investigation. Hampshire County Council has recently agreed to support the council on its approach to improvement. It is important that Councillors and senior officers embrace this external perspective and supplement these formal processes with a quarterly independent assessment of the quality of practice. This should take the form of an Ofsted like inspection of key areas of the service, undertaken by experts independent of the council. The results of these reviews should be reported to both the improvement board and Councillors. This will ensure that the council can be assured, as it moves forward, that it is making appropriate progress and that this is independently validated by experts in the field.

3.8. Finally, I would like to thank all the participants in this investigation for the time and support they have given me. I am in no doubt that this will have been a stressful experience for many, and I am grateful for the professionalism and courtesy they have shown me throughout the process.