South Gloucestershire

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: 21 November–15 December 2016

Report published: 13 February 2017

Children's services in South Gloucestershire are inadequate		
1. Children who need help and protection		Inadequate
2. Children looked after and achieving permanence		Requires improvement
	2.1 Adoption performance	Good
	2.2 Experiences and progress of care leavers	Requires improvement
3. Leadership, management and governance		Inadequate

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

Executive summary

Services for children in South Gloucestershire who need help and protection are inadequate. Performance management and quality assurance systems have not been robust enough to alert political and senior leaders to critical weaknesses. In particular, leaders have not ensured that children with disabilities receive a safe service that meets their needs and protects them from harm. Despite a recent and much sharper focus on this service, too many vulnerable children with disabilities have been left without adequate help or protection. As a result, children have been left in situations of unmet need and unassessed risk.

A turnaround board, established in 2014, has driven a number of positive and much-needed changes in children's services. Strong political support and financial investment have strengthened the progress that has been made in most areas of the service. Staff and partners report a further shift in momentum during the past year. However, practice remains highly variable. Quality assurance systems, improvement plans and the analysis of performance information have been only partially effective. Senior and political leaders have not properly understood or appropriately prioritised the well-being of all children who require help and protection. Senior and operational managers have not ensured that core social work practice is reliably in place, such as in the application of child protection thresholds.

For children at risk of harm, strategy meetings are almost always held when they are needed and, overall, agencies engage well in the initial discussions that take place to protect children. However, the police do not always attend strategy meetings when they should. Child protection thresholds are not consistently applied across the partnership, and this has left some children at risk of harm. The head of service is reviewing these thresholds, but the review is yet to have an impact. Social workers are alert to the risk of child sexual exploitation and a commissioned service provides helpful support, but the analysis of, and response to, the risk of child sexual exploitation for individual children is inconsistent and confusing. The response to care leavers at risk of sexual exploitation is weak, and most staff within the leaving care service have yet to receive training in this area of practice. Appropriate strategic arrangements and partnerships to understand the local profile of sexual exploitation are in place, but a lack of coordinated multi-agency operational oversight limits the partnership's understanding of emerging patterns or trends. When children go missing from home or care, return home interviews take place and most are helpful, but children are not seen quickly enough.

When children whose needs are clear are referred to the access and response team, triage social workers and managers swiftly refer them to the right service. When children's needs are less clear, some children experience delays in receiving the help that they need. Family and young people workers provide helpful support to families who do not meet the social care threshold, but not enough children have their needs assessed via an early help assessment. The prevalence of single-agency assessments and plans means that children's holistic needs are not fully considered. The impact of early help is not systematically analysed. Overall, children's views are heard and

those who are in need receive appropriate support. However, children's diverse needs are not well considered in assessments. When 16- and 17-year-olds become homeless, they receive a timely response and helpful support. Privately fostered children are not properly assessed and their needs are not adequately managed.

Children who cannot live with their birth families are routinely considered for adoption and are found caring homes quickly. Children looked after live in good and stable placements with family members or foster carers. Social workers care about children and know them well. The Children in Care Council is a lively and engaging forum at which political and senior leaders listen to the children's views, but the group needs to be expanded to increase its impact for all children looked after.

Written assessments for children looked after are seldom in place. Care plans for children looked after are not always clear about what children need. Risk is not always responded to well by social workers. Contingency or parallel plans are not consistently in place for children who live with family or friends. Children looked after are engaged with their reviews, but independent reviewing officers do not ensure that all these meetings happen on time, or challenge social workers and managers sufficiently when plans are delayed. Some foster carers told inspectors that delays in agreeing delegated authority adversely affect the children in their care.

Management oversight, supervision and decision making vary considerably between managers. When these are weak, plans for children are not progressed swiftly enough.

Pathway planning is not meaningful enough. In particular, plans do not help young people to develop their independence skills and not all care leavers are aware of their entitlements. Almost all live in suitable accommodation. They are in touch with their personal advisors, and these relationships are helpful to young people. More care leavers need to be engaged in employment, education and training, particularly within council services.

Governance arrangements are in place, although they have not been effective in identifying and addressing some key service weaknesses. Plans and priorities across the partnership are becoming increasingly aligned and performance reports are now shared with the right forums. The collation of performance information is made more difficult by weaknesses in the client record system. The oversight of caseloads, including the practice of allocating children's cases to managers, is not robust.

Practitioners are proud to work for South Gloucestershire and consistently say that services are improving. They feel well supported and cared for by visible and approachable managers. They value the training that they receive, particularly in relation to the chosen model of practice, but the analysis of training needs across the service is not systematic enough. Social workers do not have sufficient understanding of domestic abuse within families.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates one children's home. It was judged to be good at its most recent Ofsted inspection.
- The last inspection of the local authority's safeguarding arrangements was in August 2012. The local authority was judged to be adequate.
- The last inspection of the local authority's services for children looked after was in August 2012. The local authority was judged to be adequate.

Local leadership

- The director of children's services (DCS) has been in post since January 2013.
- The DCS is also responsible for education, adult and housing services, and public health and well-being.
- The chair of the Local Safeguarding Children Board (LSCB) is currently vacant, due to the unexpected resignation of the independent chair, effective from 31 October 2016.

Children living in this area

- Approximately 57,888 children and young people under the age of 18 years live in South Gloucestershire. This is 21% of the total population in the area.
- Approximately 11% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in nursery and primary schools is 11% (the national average is 17%)
  - in secondary schools is 11% (the national average is 15%).
- Children and young people from minority ethnic groups account for 7.2% of all children living in the area, compared with 21.5% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Mixed and Asian British.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 7.4% (the national average is 20.1%)
  - in secondary schools is 6% (the national average is 15.7%).

[2] The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data, when this was available.

Child protection in this area

- At 31 October 2016, 973 children had been identified through assessment as being formally in need of a specialist children's service during the previous 12 months. This is a reduction from 1,721 at 31 March 2016.
- At 31 October 2016, 153 children and young people were the subject of a child protection plan. This is a reduction from 173 at 31 March 2016.
- At 31 October 2016, nine children lived in a privately arranged fostering placement.
- Since the last inspection, four serious incident notifications have been submitted to Ofsted and one serious case review has been completed.

Children looked after in this area

- At 31 October 2016, the local authority is looking after 168 children (a rate of 29.2 per 10,000 children). This is an increase from 165 (29 per 10,000 children) at 31 March 2016. Of this number:
  - 48 (or 28.6%) live outside the local authority area
  - 14 live in residential children's homes, of whom nine live out of the authority area
  - three live in residential special schools, of whom two live out of the authority area
  - 123 live with foster families, of whom 21.1% live out of the authority area
  - three live with parents, none of whom live out of the authority area
  - 11 children are unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been nine adoptions
  - 22 children became the subject of special guardianship orders
  - 88 children ceased to be looked after, of whom 3.4% subsequently returned to be looked after
  - 26 children and young people ceased to be looked after and moved on to independent living
  - no children and young people ceased to be looked after or are now living in houses in multiple occupation.

The casework model used in this area

- 'Signs of Safety'.

Recommendations

1. Urgently review all cases currently or recently allocated to managers within the 0–25s disability service, ensuring that all children receive a timely service commensurate to their needs from staff and managers who have the right skills and experience to help them.

2. Strengthen arrangements to identify patterns, trends and links for children who are at risk of sexual exploitation.

3. With the South Gloucestershire Local Safeguarding Board (SGLSB), implement clear guidance for staff and managers to ensure that they understand the steps required to identify, assess and reduce the risk of child sexual exploitation.

4. Ensure that the completion of welfare checks in the access and response team does not delay the provision of help to families and that decision-making is timely. Strengthen management information systems in the service to enable managers to monitor timescales more closely.

5. Ensure that child protection thresholds and decisions, including the application of the significant harm threshold, are known and understood across the partnership. Review local procedures and training for staff to ensure that these, and practice, comply with the requirements of guidance and legislation and that comprehensive multi-agency information relating to all members of children's households inform the analysis of risk. Ensure that all agencies, in particular the police, engage fully in all relevant child protection processes.

6. Improve the timeliness of return home interviews for children who go missing from home or care to understand more quickly why they went missing and what happened while they were away.

7. Review the use of South Gloucestershire's early help assessment process and take steps to ensure that agencies work closely together to meet the needs of individual families. Ensure that, when appropriate, early help plans are in place, shared with families and informed by an assessment of need.

8. With the SGLSB and relevant partners, take steps to evaluate the impact of the provision of early help support for families, using this information to inform the development of early help services.

9. Ensure that the new client record system is implemented as quickly as possible. Ensure that in the intervening period children's electronic files

properly evidence the work undertaken with children and families and enable proper sharing of information between teams and agencies.

10. Improve social workers' knowledge and understanding of domestic abuse to ensure that risks are identified and understood, and lead to the provision of appropriate support.

11. Take steps to improve the consistency and timeliness of response to children who are privately fostered.

12. Ensure that the diverse needs of children and their families are considered through assessments and, when appropriate, inform plans for children.

13. Improve the quality of assessments and plans for children looked after to ensure that they reflect children's changing circumstances and needs, and that they are clear, analytical and focused on improving outcomes.

14. Improve the early consideration of permanence options for all children who cannot live with their birth families. Ensure that parallel planning and contingency plans for children are clearly recorded in their case files.

15. Undertake a review of the training undertaken by all staff within the service to ensure that support workers, social workers and managers are properly equipped to understand the risks and needs relating to, for instance, 'missing' protocols, child sexual exploitation and domestic abuse.

16. Implement clear standards for recording within the children in care team, to include the recording of management decisions and supervision. Ensure that regular and good-quality supervision and performance appraisal are evident across all teams within the service.

17. Improve the timeliness of children's looked after reviews and strengthen the role of the independent reviewing officer service in challenging plans that are not progressed quickly enough for children.

18. In partnership with care leavers, review the pathway planning process so that it is meaningful to young people and is more helpful in ensuring that their outcomes improve.

19. Take further steps to close the gap between care leavers and all local young people in relation to employment, education and training. Increase opportunities for care leavers to work, train and gain employment experience within the council.

20. Make sure that all care leavers are aware of, and are regularly reminded about, their entitlements as care leavers.

21. Ensure that the quality assurance framework is effective in ensuring that managers and leaders at all levels understand strengths and weaknesses in the provision of help, protection and care of children in every part of the service. Make sure that quality assurance activity, including complaints, properly informs actions and plans. Ensure that whole and individual service plans properly prioritise actions to address critical weaknesses.

22. Implement caseload management guidance, including clear standards relating to the allocation of work to managers.

Summary for children and young people

- Ofsted last inspected services for South Gloucestershire children who need help, protection or care in 2012. At that time, inspectors judged services to be adequate. In 2014, senior managers decided that they needed to make some big changes and set up a 'turnaround board'. Some improvements have been made.
- This inspection found that too many children, particularly those with disabilities, are not being properly protected or helped. These families have experienced distress due to delays in accessing help. Because this is so serious, the judgement for this inspection is inadequate. Other children, like those who are adopted, children looked after and care leavers, receive better support.
- Children who are referred to children's social care because they are at risk are helped quickly. Families who have problems that are less serious receive support to stop their difficulties getting worse, although professionals from different agencies often don't talk to each other to work out what these families need.
- When it is not clear how serious the problems are, it sometimes takes social workers too long to decide what is needed, and these families have to wait to be helped.
- When children go missing they aren't always seen quickly enough when they return, to find out why they ran away. When children are seen, the conversations are helpful.
- Managers and other agencies have worked hard to understand how many local children are at risk of sexual exploitation. Help is provided to most of these children, but social workers and managers don't always do the right things to understand the risks for these children. This means that children are not always protected well enough.
- When it isn't possible for children to live with their parents, they live in good homes with family members or foster parents. They go to school regularly, have fun and talk about the things that worry them. Social workers care about children and know them well.
- Professionals think carefully about whether children who can't live with their own families should be found an adoptive family. These children are found loving homes quickly.
- When young people leave care, they are helped by personal advisors who see them often and work hard to support them. Pathway plans are long documents that are often not useful to young people. The office where personal advisors work isn't a warm or welcoming place for young people to visit.
- Too many care leavers are not in education, employment and training. Senior managers need to offer these young people more training and job opportunities within the council.
- Senior managers and local politicians take an active interest in children looked after and care leavers. They listen to what children say and try to make their lives happier. They need to help the Children in Care Council grow so that it can better represent all children in care.

The experiences and progress of children who need help and protection	Inadequate

Summary

Senior managers have not taken sufficient and timely action to ensure that children are safeguarded. Too many children have been left at risk of harm or without their needs being met.

Serious and widespread weaknesses in the 0–25 disabilities service have resulted in large numbers of vulnerable children not receiving the help and protection that they need. Some 172 children with disabilities have been nominally allocated to managers yet not had their needs properly assessed, reviewed or met. Many of these children have high-level needs or require statutory intervention. Some children and families had not been seen by a social worker for many months.

Some areas of child protection practice are weak. When children are at risk of harm, most agencies engage with multi-agency strategy meetings, although the police do not always attend. The risk of significant harm is not always considered through a child protection section 47 enquiry, and the quality of enquiries is too variable. The application of child protection thresholds for children at risk of sexual exploitation is inconsistent, with confusion about the steps needed to analyse and address risks. A commissioned service provides support, but a coordinated and agreed approach across the partnership to managing risk is not in place.

Early help assessments are generally of a good quality, but they are not undertaken for all children who would benefit from one. The family and young people service provides helpful support. However, not all children receive a coordinated multi-agency response to their needs. Thresholds for referral to children's social care are applied effectively. When the level of need is clear, children receive a proportionate and timely response. However, delays in completing welfare checks mean that some children, whose needs are less clear, wait too long for support.

Single assessments are timely. Support is provided while children's needs are being assessed. Children's voices are evident, but the quality and impact of plans are variable. Delays in assessing and visiting children who are privately fostered mean that these children's circumstances are not properly overseen. Young people who present as homeless are well assessed, with appropriate provision of help.

Children missing from home are quickly identified and offered return home interviews. Interviews are detailed and lead to appropriate support. Many return home interviews do not take place within 72 hours. Effective arrangements are in place to track children who are missing education.

Inspection findings

23. At the time of the inspection, 172 children with disabilities were allocated to the service manager and the team manager responsible for the 0–25s disability service. Some of these children have high-level complex and specialist needs requiring social work assessment, oversight and support. Others require a lower-level service to oversee and review packages of support. Sixty children were waiting to be re-allocated following the departure of a number of social workers from the service. The remaining 122 children were classed as 'open for review', and had been appropriately transferred to the 0–25s disability service from special educational need coordinators.

24. Inspectors sampled cases in the children with disabilities service and found too many children whose needs had not been assessed or reviewed for many months. Sixty-four children had not been seen by a social worker for over 18 months, and 31 of these children were eligible for a specialist social work service. Some were at risk of significant harm from domestic abuse or child sexual exploitation. Others were living in families under acute stress without appropriate support. Duty systems to respond to parents' and professionals' concerns were largely ineffective. (Recommendation)

25. The 0–25s disabilities service was transferred from adult services to children's services in July 2016. At this point, the head of service established a turnaround board, chaired by the director of children's services, to begin to address the critical weaknesses in the service. Efforts were made immediately to improve recruitment activity and stabilise the workforce. Steps were taken incrementally to address the backlog in work and to review some families in the light of previously unassessed child protection concerns. These actions have not been timely or effective enough, leaving too many children at risk of harm and without their needs being met for too long. After inspectors raised concerns with senior managers, they took swift and decisive action to understand children's circumstances and to allocate those identified as the highest priority.

26. The early help offer, delivered through the family and young people service (FYPS) service, provides helpful support for families, including targeted youth support and parenting programmes. Inspectors saw examples of purposeful work with families being undertaken by staff from this service, particularly alongside social workers. However, not all families receive help at the time they need it, and partners reported that some families wait two to three months for a service. Although FYPS workers try hard to stay in touch with fellow professionals, the recording systems in the service are complex, duplicative and confusing, reducing the ability of staff properly to record and share their work.

27. South Gloucestershire's single assessments for early help are not sufficiently embedded in the delivery of early help. Services to families with a range of needs are often provided without an assessment having been undertaken, and in most cases that were seen by inspectors, no early help assessment was evident. Many support plans are single-agency and are of an inconsistent quality, with professionals working in parallel but with an absence of joined-up thinking, sharing of information or a coordinated offer of help to meet children's needs. The safety mapping tool is often used as a referral, an assessment and a plan, but it does not contain sufficient information to be used in this way. It is also frequently the only document that is shared with families.

28. Some 87% of children referred to the access and response team (ART) have not been subject to an early help assessment and, in most cases seen by inspectors, a large number were passed back to the referrer to undertake this piece of work. When early help assessments are undertaken, the majority demonstrate a clear understanding of children's needs. They lead to helpful 'team around the child' meetings and appropriate multi-agency packages of support. A greater number of children and families would benefit from this coordinated multi-agency response to meet their needs before their problems become worse. (Recommendation)

29. Social workers and managers in the ART promptly process all referrals to children's social care. Consent from families is routinely and comprehensively considered, and is recorded on children's case files. Children who are immediately identified as requiring early help or social care support are swiftly referred to the right service. However, the rationale for these decisions is not always clearly recorded on children's case files. Delays prevent some children, for whom further enquiries are needed, from being assessed or receiving help in a timely way. Inspectors found a large number of children who had waited in excess of five days for the completion of welfare checks to enable social workers to decide what help they needed. Senior managers responded quickly to inspectors' concerns and reviewed all cases in this part of the service. Senior managers also took appropriate action to immediately strengthen the management oversight and monitoring of this work. (Recommendation)

30. The emergency duty service has sufficient capacity to respond to requests for help outside of office hours. A close working relationship between the emergency duty service and the ART ensures that there is helpful information sharing and a coordinated response to children in need of help and protection.

31. When children are considered to be at risk of significant harm, strategy meetings are held. Multi-agency attendance and sharing of information to

inform decisions about risk are generally good, although inspectors reviewed a number of cases in which police engagement was considered key yet they did not attend. The inconsistent engagement with police is of particular concern for children who are at risk of sexual exploitation. Minutes of strategy discussions provide a detailed overview of information shared, but the explicit consideration of the significant harm threshold was absent from the vast majority of cases seen. There is a lack of clarity about the purpose of these discussions, with professionals often discussing whether a child protection conference is needed before a section 47 child protection enquiry has been undertaken. (Recommendation)

32. Inspectors identified nine cases when the significant harm threshold had been met, yet a child protection section 47 enquiry had not been undertaken. This left children in situations of unassessed risk, for example when multi-agency checks had not been undertaken to establish the potential risk posed by key adults in children's households. Inspectors found a lack of clarity and understanding about the purpose of section 47 enquiries and, in some cases, poor attention to responding in a timely way. Section 47 enquiries are variable in quality and do not always adequately consider needs and risks relating to brothers and sisters. Adult information, such as that held by health and probation, is not consistently included. (Recommendation)

33. In most cases seen by inspectors in which a section 47 child protection assessment had been undertaken, decisions about whether to convene a child protection conference were appropriate. However, the rate of these enquiries, at 121 per 10,000 children, is much lower in South Gloucestershire than comparators and only 25% of section 47 enquiries result in an initial child protection conference. In addition, the reduction in the number of children subject to a child protection plan, from 221 at 31 October 2015 to 153 a year later, warrants further and closer scrutiny by senior managers. The head of service has made a promising start to analysing the application of child protection thresholds and has identified inconsistent decision making by a few managers who have since left the service. This analysis needs to continue with greater rigour and focus to ensure that all children who have suffered or who are likely to suffer significant harm benefit from a comprehensive assessment of risk and, when appropriate, a multi-agency child protection plan. (Recommendation)

34. Children's views inform conferences and all children are offered an advocate. Children who spoke to inspectors said that they had found this support to be helpful. One young person said that these meetings used to scare her, but that they are now 'more child friendly'. Another said of her advocate, 'She tries so hard for us', 'She does things straight away' and 'She takes time to understand us'.

35. Child protection conference chairs are suitably experienced and the team is stable. Inspectors observed well-chaired child protection conferences with a clear analysis of risks, using the local authority's chosen approach to assessment. However, child in need and child protection plans are variable in quality. They are reviewed within appropriate timescales, but often lack clear and timely actions. This leads to a lack of targeted support for some children. Core group meetings are held frequently and records of meetings demonstrate consideration of progress against plans. Social workers visit children regularly and work is purposeful. Partner agencies report strong partnership working to ensure that children are helped and protected. When change is too slow or the concerns increase for children who are subject to child protection plans, managers make appropriate decisions to escalate these concerns through the Public Law Outline.

36. When children are at risk of sexual exploitation, social workers are alert to these concerns. However, the local authority's own case audits have identified that sexual exploitation risk assessments often lack a clear analysis of risk, and this is linked to a lack of multi-agency training to enable professionals to complete these risk assessments well. This was confirmed in cases reviewed by inspectors.

37. At the time of the inspection, 19 children were assessed to be at medium or high risk of child sexual exploitation, including seven children looked after. Guidance to social workers does not provide sufficient clarity about the process that they should follow to understand, assess and reduce risk. Cases seen by inspectors evidenced an inconsistent approach to understanding the wider needs of children at risk of sexual exploitation. For example, some child sexual exploitation strategy meetings are overly focused on whether a child protection conference would be appropriate. Further, child protection section 47 enquiries are not always undertaken when the threshold for significant harm is likely to be met and, when these enquiries are undertaken, they rarely consider the wider family, including brothers and sisters. While a commissioned child sexual exploitation service provides targeted help to most children who need it, overall the impact of work is inconsistent, because it is not always linked to a comprehensive assessment of risk and need. (Recommendation)

38. A child sexual exploitation network meeting is chaired by the police and appropriately considers perpetrators and disruption activity. Senior managers and partners recognise that a multi-agency risk management pathway and panel are needed to consider children at risk of sexual exploitation. This is due to be launched in March 2017. Consultant social workers provide advice and support to social workers, and follow up actions about individual children.

However, there is no strategic multi-agency oversight of all children at moderate or high risk of child sexual exploitation. This is a missed opportunity to identify links and patterns between children, places and perpetrators. (Recommendation)

39. Arrangements for tracking and supporting children who are missing from home are effective for most children. Children are quickly identified and are offered meaningful return home interviews by FYPS workers. These discussions with children and young people frequently lead to targeted support. Close monitoring of missing children through weekly and monthly reports enables managers to maintain an overview of numbers of children who go missing and how many receive a return home interview. Delays in the police sending notifications about missing children to children's social care have adversely affected the timeliness of return home interviews. Through discussion with police this issue has largely been addressed. However, further improvement in timeliness is still needed. While 80% of return home interviews are completed, and 86% of children are contacted within 72 hours of their return, only 54% of face-to-face interviews occur within 72 hours. In some cases reviewed by inspectors, children were not seen soon enough after they had gone missing to allow for a meaningful conversation about what had happened and why. (Recommendation)

40. For the majority of children, single assessments are completed in good time. Managers review timescales for completion to reflect children's changing needs. This is a strength. In the vast majority of cases, children's views inform assessments, children are seen alone and their wishes are well reflected in plans. There is good engagement of fathers and wider family members; inspectors reviewed many cases when fathers had been listened to and helped to have meaningful and safe relationships with their children. In almost all cases seen by inspectors, purposeful work takes place while assessments are being completed. This helps to inform assessments and ensures that families receive timely support, often during times of crisis.

41. In some assessments, the focus is predominantly on presenting issues, with insufficient attention to wider family circumstances and history. Children's diverse needs are not well understood or articulated in the majority of assessments. Almost all assessments are signed by managers, but there is little evidence that they routinely provide any rationale for their decisions. (Recommendation)

42. Domestic abuse referrals are not routinely filtered or screened by the police and are not all appropriate referrals to children's social care. This leads to social workers spending time analysing referrals that do not require a children's services response. Social workers do not routinely undertake

domestic abuse risk assessments and few cases are referred to the multi-agency risk assessment conference (MARAC) by children's social care. Social workers' knowledge of domestic abuse is variable and is rarely informed by research. This limits their ability to assess properly the impact of domestic abuse on children's experiences. Children who have experienced domestic abuse benefit from a support programme, but there is currently a six-month waiting list. Victims can access the support that they need, but a programme for perpetrators has yet to be commissioned. When victims and their children are referred to MARAC, children's safeguarding needs are carefully considered. The MARAC process is well established, with a wide range of agencies engaged, including children's social care. (Recommendation)

43. Multi-agency public protection arrangements are effective in managing the low volume of high-risk offenders. Meetings ensure that risks to children are fully explored and that there is detailed scrutiny and follow-up.

44. Awareness raising about private fostering has been undertaken, and the annual private fostering report covers pertinent areas. However, for a number of children who are privately fostered, there are delays in completing assessments. Visiting timescales are not consistently met. (Recommendation)

45. The needs of the small number of 16 and 17-year-old young people who are at risk of homelessness are well assessed. Coordinated work with housing services ensures a timely response to young people's needs, and decision making is prompt. Appropriate use is made of emergency accommodation. Partners have demonstrated their commitment to the new youth housing panel. Social workers make young people aware of their entitlements, including, when appropriate, the right to become a child looked after.

46. At the time of the inspection, 209 children were receiving elective home education. Of these, 15 have special educational needs. None are children looked after. Home visits are undertaken at least once a year, and children are spoken to and their progress is carefully monitored. The local authority holds an up-to-date register of these children and their families. A safeguarding officer follows up any safeguarding concerns. However, information about what the children do once they have completed the statutory phase of their education is not systematically collected.

47. Currently, 30 children missing educational provision are tutored by qualified teachers who receive full safeguarding training. They keep records for each child on a central register which they review on monthly basis. A new post has been created to coordinate and oversee progress. None of the children receiving alternative provision are children looked after. The local authority is aware of the reasons why the children are not in full-time education. A large

proportion has medical, emotional and special educational needs. An attendance officer rigorously follows up children missing education in line with published guidelines and takes appropriate steps to ensure that the whereabouts of these children are known.

48. Appropriate processes are in place to ensure that referrals concerning allegations against staff are responded to promptly, and advice is given to agencies as needed. Thresholds are consistently applied and a database is in place to track cases to conclusion. Recording of discussions with concerned professionals could be further improved.

The experiences and progress of children looked after and achieving permanence	**Requires improvement**

Summary

In order to improve outcomes for children looked after, a specialist looked after children's team was established in June 2015. The experiences of children looked after are getting better, but they require further improvement to be good.

Decisions to look after the majority of children are timely and well considered, but a small number wait too long to be looked after and, as a result, their circumstances deteriorate. Most children who leave care to live with a family member receive effective support. The Public Law Outline is managed well, overall, although there is delay in achieving permanence for some children. Health assessments are timely and well considered. Most children live in good-quality local placements with their brothers and sisters, but not all experience good outcomes. The fostering service supports carers well, but delegated authority is often delayed. To improve placement choice, more carers are needed. Children who are suitable to be adopted are promptly identified, matched and placed with families.

Social workers regularly visit children looked after and know them well, wherever they live. However, written assessments are not always in place. The independent reviewing officer (IRO) service reviews most children regularly, but IROs do not always provide effective challenge to ensure that care plans are progressed quickly.

The response to children who are at risk of child sexual exploitation is not sufficiently robust. Return home interviews for children who go missing from care are helpful, leading to appropriate support, but they are not always timely.

Educational outcomes for children looked after, although improving at key stages 1 and 2, are not yet good enough at key stage 4.

Corporate parenting is well established and senior and political leaders prioritise the needs of children looked after. The Children in Care Council is increasing in scope and impact, but senior managers need to do more to ensure that the forum represents children of all ages and circumstances. The advocacy and independent visitor service is well established.

The transition to independence team stays in touch with nearly all of its care leavers, who receive helpful support from personal advisers for their accommodation, health and medical needs. Pathway plans are not yet good enough, and care leavers do not value them. Not enough care leavers are in employment, education and training, and insufficient opportunities have been made available to young people to work or develop their employment skills within the council.

Inspection findings

49. Social workers and the family and young people service (FYPS) workers make sustained efforts to ensure that children remain within their families when it is safe to do so. Recent decisions to look after the large majority of children are timely and appropriate, and risks to children are responded to effectively. Young people at risk of family breakdown benefit from specially commissioned mentoring and respite at weekends. Intensive direct work undertaken by FYPS workers helps families to make positive changes, and schools play an active role in providing additional support. In those cases reviewed by inspectors, two older children were not accommodated early enough, and these young people had experienced continued or increasing risk.

50. At the time of the inspection, South Gloucestershire looked after 173 children. The rate of children becoming looked after on 31 March 2016 was 29 per 10,000, which is half of the rate for England and substantially lower than that of comparators. This figure has remained steady since 2013.

51. When children return home from care or are placed permanently with family members or other people whom they know, appropriate arrangements and direct support are in place for most children and their families. Supervision orders, special guardianship order (SGO) support plans and children in need plans are used appropriately and are helpful to families. In the 12 months prior to the inspection, 88 children ceased to be looked after. A very small number subsequently returned to be looked after. For a very small number of children, support is not properly targeted to meet their needs, leading to repeat care episodes or to children's needs not being fully met.

52. For the majority of children looked after, written assessments are not in place. Those that are undertaken are not sufficiently analytical and do not reflect children's changing circumstances. Although, for some children, important

information is recorded, this is not always so, such as placement matching documents or court statements. The effect on children is that plans are not routinely informed by up-to-date assessments. In addition, it is difficult to see how emergency care arrangements or packages of support can properly meet the needs of children looked after when social workers and managers do not have access to comprehensive and up-to-date information. (Recommendation)

53. Care plans seen by inspectors are of inconsistent quality. For example, they are not specific enough, they are not regularly updated and contingency arrangements are not fully considered. This makes it difficult for children, families, carers, managers and independent reviewing officers (IROs) to measure and track actions, or to judge whether children's lives are improving. (Recommendation)

54. For the majority of children, there is appropriate and timely use of pre-proceedings and care proceedings. Effective oversight and tight scrutiny by the service manager and the legal team are in place to avoid delay and, while there are some minor delays in pre-proceedings work, overall this work is effective. Parenting assessments, connected person's assessments and viability assessments are of sufficient quality to inform decision making, and are routinely used in court work. This avoids the need for externally commissioned independent assessments.

55. The local judiciary and the children and family court advisory and support service are positive about working relationships with the local authority and, in discussions with inspectors, commended the quality and timeliness of pre-proceedings and care proceedings work. The timeliness of care proceedings has improved substantially over the past 12 months and consistently meets the 26-week target.

56. Overall, cases seen by inspectors evidenced a commitment to parallel planning or 'twin tracking' with children's birth families or extended families to support them in caring for their own children permanently. The local authority has a higher number of SGO arrangements than the national average. In 2014–15, 19% of children left care via an SGO, compared with 11% in England. Figures for the six months leading up to the inspection suggest that this trend is continuing.

57. In some cases seen by inspectors, the progression of plans for permanence were delayed. Although plans for children who are suitable for adoption are progressed well, for a small number of children who require other permanent care, plans are not progressed in a timely way. Case records do not always evidence the consideration of alternative permanence options outside of children's extended families or that contingency plans are in place. This means

that a small minority of older children have delays in achieving permanence, for example when there are complexities in finding the right family for them or when family assessments are undertaken sequentially rather than concurrently. Senior managers acknowledge that, in order to provide a consistent and timelier response for all children, permanence tracking needs to be more rigorous. (Recommendation)

58. At the time of the inspection, 78 children looked after were cared for under a voluntary section 20 care agreement. In order to satisfy themselves that appropriate care plans are in place, senior managers conducted a thorough review of all section 20 arrangements. This was prior to the start of the inspection. They concluded that for 52 of these children the legal status was suitable, mainly because a large proportion were age 16 or 17 and unlikely to benefit from legal permanence. For the 26 children who were assessed as requiring permanence, appropriate action has been taken. Twenty children are matched with long-term carers, and plans are in place to secure permanent arrangements for the remaining six children.

59. Of the current cohort of 104 children who are looked after, 59 attend schools judged by Ofsted as good or outstanding and four attend schools judged as inadequate. The head of the virtual school and her team know all the schools and the pupils very well. They work closely with schools to ensure that children looked after attend the schools that are most suitable for them.

60. Children looked after made good progress from their starting points at key stages 1 and 2 in 2016. At key stage 1, all children achieved the expected standard in mathematics, and most in reading.

61. Of the 11 pupils at key stage 4 in 2016, two children looked after gained a minimum of five A* to C GCSEs including English and mathematics. Five have special educational needs. All children in the cohort made a successful transition to further education and training. The overall attendance in 2015–16 by all 115 children looked after in this cohort up to the end of key stage 4 was 93%. This is just below the national average for all children. The attendance of primary-age children looked after was 97.5% and for secondary pupils was 90%. In 2015–16 there were no permanent exclusions from schools for these children.

62. The virtual school team agrees and reviews appropriately challenging targets for children looked after, and a member of the team provides specialist help that benefits children, including art therapy. Vulnerable pupils also receive a boost by attending the TOAST centre, where they improve their self-esteem, giving them greater confidence when they make the transition between schools. Those who need extra help or support to increase their emotional

well-being, or those with a disability, enjoy and value taking part in a well-established mentoring programme.

63. The revision and audit of personal education plans (PEPs) have resulted in plans being more helpful and informative. Children, teachers and foster carers find them useful in providing a clear focus for planning and reviewing children's progress and attainment. PEPs capture the voice of each child well and include how they view their own performance and achievements. PEPs are encouraging and challenging, with clear targets to help pupils to improve specific aspects of work, including attendance, English and mathematics. The virtual school headteacher and her team ensure that schools use effectively the additional funds, such as the pupil premium, to improve academic, social and personal skills. Spending on sports coaching or music tuition and extra English and mathematics lessons greatly benefits pupils.

64. In 2016, the local authority commissioned a survey of all children and young people in schools up to the end of key stage 4 to assess their experiences of bullying and awareness of keeping themselves safe. Staff in the virtual school are aware of the issues arising from the survey and, as a result, they are working with schools to raise awareness and deal with bullying.

65. Transition arrangements for children looked after to further education or apprenticeships work well. It is too early to evaluate the impact of the recent establishment of a virtual college. Its purpose is to improve the monitoring and support for young people as they become care leavers and reduce the numbers of those who do not continue in education, training or employment.

66. The majority of children are seen regularly and alone by their social workers, and within statutory timescales. This includes children who live outside of South Gloucestershire. Most children who spoke with inspectors were positive about these relationships. One child said that his social worker is 'the best' and another said that her social worker had found her another placement when she was not happy living with her previous carers. However, a few children said they had been upset by many changes in social worker, and one child told inspectors that 'absolutely no one stays for long'. Inspectors found that, for a minority of children, their views were recorded but not fully taken into account, or there had been inconsistent efforts to engage with them.

67. The independent visitor and advocacy service is well established via a commissioning arrangement. Twenty children have been carefully matched with an independent visitor, including those who live outside of South Gloucestershire. Children know how to complain, and the complaints manager has established helpful links with the advocacy service to facilitate the sharing of issues and concerns. The complaints team progresses individual complaints,

prompting managers and social workers to respond to children's worries and representations. Learning is shared with staff using children's own words.

68. When children looked after are at risk of child sexual exploitation, the response to this risk is not consistent. For example, inspectors saw variable use of risk assessments to inform planning, and actions to support and safeguard young people are not always timely enough. Operational oversight of child sexual exploitation is variable. Senior managers consider risks for individual children. However, the overarching patterns and trends for all children looked after who are at risk of child sexual exploitation are not routinely analysed or identified on a multi-agency basis. This reduces the effectiveness of work to protect children. (Recommendation)

69. For children and young people who go missing from care, return home interviews are not always completed with 72 hours. However, when children are engaged appropriately, the quality of the work is of sufficient depth to inform planning and future actions to safeguard them. When young people offend, or misuse alcohol or drugs, a range of appropriate and specialist services are in place to offer timely support and advice. (Recommendation)

70. Appropriate and thorough arrangements are in place to undertake initial and review health assessments. The designated nurse provides consistency to young people who live in South Gloucestershire and also those who live out of the area. The inclusion of PEPs in the health review process during the 12 months preceding the inspection, and recent steps to ensure strengths and difficulties questionnaires are used well, are further improving the quality and impact of health assessments. Specific support for emotional health and well-being is available from the 'Thinking Aloud' service, enabling children and their carers to access psychological help and support.

71. The quality of case recording is too variable. Some recording is poor, with little evidence of the direct work with children that social workers and carers describe. Key documents are sometimes missing from case records. Better files evidence detailed attention to children's views and feelings. For these children, records demonstrate how their wishes are informing care plans and provide a clear account of contact with their birth families. Senior managers need to address this inconsistency to assure themselves properly of the quality of casework and to ensure that children can benefit from a comprehensive account of their care experiences, should they choose to read their records in the future.

72. Management oversight and decision making is inconsistent, and case supervision is not always evident on children's files. Although social workers describe helpful oversight and support, inspectors found a correlation between

poorly evidenced management direction and delays in progressing plans for children. (Recommendation)

73. For the vast majority of children, placements are of a good quality. They are mostly local, and children are carefully matched according to their needs. This includes their cultural needs, family history and any disability. For asylum-seeking children, their language and ethnicity are carefully explored as part of the placement matching process. Children placed out of area benefit from visitor of support from health, education and other agencies, such as the youth offending team. Brothers and sisters are routinely placed together.

74. Short-term and long-term placement stability is achieved effectively through appropriate matching, placement stability meetings, and helpful training and support for foster carers. In 2014–15, only 6% of all children looked after experienced three or more placements. Long-term stability is also good and improving, with 67% of children having remained in the same placement for two years or more as of March 2015, rising to 79% in March 2016 and to 86% in October 2016. This is much higher than comparators.

75. Contact arrangements for children with their families are well considered and facilitated by carers, family members or support workers who are known to children and their families. This provides familiarity and consistency, ensuring that the time that children spend with their families and friends is properly facilitated and assessed.

76. The local authority's sufficiency strategy includes key challenges and priorities, including the need to increase the choice of semi-independent accommodation for care leavers. The strategy identifies further work that is needed to improve the recruitment of foster carers and the regional commissioning of residential placements. Some actions are being progressed well. For instance, a well-planned and targeted recruitment campaign for foster carers is in place, with nine assessments in progress.

77. The fostering service operates within the regulatory framework, but there are some areas for further improvement. For example, only 80% of foster carer reviews are completed within timescales. Foster carers told inspectors that they are supported well, and spoke positively about the availability and helpfulness of training, including online courses. However, delegated authority often takes too long, and only one of the six carers who met with inspectors said that they had a written delegated authority agreement. (Recommendation)

78. Children and young people who spoke with inspectors said that they access a wide range of leisure activities. Free leisure passes are actively promoted by

carers, social workers and virtual school staff, and the pupil premium is used to provide further access to leisure activities.

79. Most children, 90%, contribute to their reviews. A clear system is in place for IROs to escalate concerns. However, they do not consistently articulate or scrutinise children's plans for permanence. Inspectors saw examples when children's reviews had not challenged delays in progressing these plans.

80. The Children in Care Council is developing its scope and is beginning to increase the number of children looked after who are involved in the group. However, senior managers and leaders need to support the group to enable it to expand further, so that a greater range of children looked after are represented. While numbers involved are still small, there is lively and enthusiastic engagement to improve the lives of children looked after, and children benefit from enjoyable events and celebrations.

81. Clear governance arrangements and a positive commitment to corporate parenting are evident in the council and among key partners. There is a particularly strong focus on improving educational outcomes and increasing the availability of work experience and apprenticeships. Young people's participation at the corporate parenting steering group is improving and is better organised. The contribution that they make is valued, and informs priorities and service development. For example, the Children in Care Council produces a video in which it asks questions of the corporate parenting group, which then replies by video. This is the children's chosen method of communication and one that they enjoy. This has resulted in the council approving the use of a Facebook and Twitter account which will start in January 2017. It will be a shared venture between the Children in Care Council and the virtual school.

The graded judgement for adoption performance is that it is good

82. The local authority identifies children who may be suitable for adoption through effective parallel planning from the onset of care proceedings, although these plans are not always easily identifiable within children's files. A substantial number of these children do not move to adoptive placements, as proportionately more children are placed with extended family members under SGOs or through connected person's arrangements than in any other local authority. For the 12 months to October 2016, 22 children left care through an SGO, more than double the number of children who left care through adoption. Consequently, the numbers of children who are adopted each year are comparatively fewer than in most other local authorities.

83. The local authority places children for adoption in good time. Performance has improved substantially since the last published Department for Education adoption scorecard (2012–15). The average period of time from children receiving court authority to placement with their adoptive families has also reduced markedly.

84. Stable, effective frontline management arrangements and a comprehensive service action plan have resulted in improvements in the adoption service. Parallel adoption planning is considered early. Potential adopter matches and preparation work proceed quickly through two adoption social workers working jointly with locality social workers. Concurrent foster-to-adopt placements are established early to minimise disruption for children, with three placements made in the past year and seven adopters being 'dual approved' since 2015.

85. Adopters from diverse backgrounds are approved, including single carers and same sex couples. The local authority has a long-standing history of approving more adopters than they need in order to place South Gloucestershire children who are waiting for adopter matches. At the time of the inspection, six adopters were awaiting a match, two of whom had been approved very recently. Two children recently approved as suitable for adoption were linked with a possible adoptive match. Newly approved adopters wait an average of four months for matches with children. Most children are matched with an adoptive family promptly.

86. The local authority has provided adoptive families for children from a wider spectrum of backgrounds in the year preceding the inspection. Over a third of 19 children approved for adoption or who are in adoptive placements are aged over five years, and the oldest child is aged 10 years. Two brother and sister groups and two children with disabilities were matched with adopters. Approximately the same proportion of children from Black and minority ethnic backgrounds (BME), 8.3%, were adopted during 2013–16 as are represented in the 9% of BME children living in the local authority. Senior managers have identified that children from a broader range of ages and backgrounds should have opportunities to live in adoptive families and are actively raising awareness through closer links with locality teams, encouraging 'greater aspiration' and increased understanding among social workers.

87. Adopter assessments are uniformly strong. Probing explorations of applicants' personal histories, relationships and motivations in seeking to adopt children are evident. Balanced and proportionate social work reports evaluate applicants' strengths and potential vulnerabilities. Regulatory checks and references are scrupulously undertaken and documented. Assessments are

completed within six months, with any delays being triggered by applicants rather than by shortcomings in the adoption service.

88. Careful consideration is given to brothers and sisters remaining together or apart, based on assessments carried out by professionals with sufficient expertise, including clinical psychologists. Adopters told inspectors that preparation training provided by a pan-regional organisation is thorough and challenging. Training evaluations capture applicants' levels of participation and engagement, informing their assessment reports.

89. The availability and quality of adoption support are highly regarded by adopters whose children were placed with them as long as 10 years ago, and also by new adoptive families. A wide range of therapeutic programmes, commissioned from approved providers, provide targeted interventions for children, adoptive parents and families. Therapeutic support concentrates predominantly on attachment difficulties, typically arising during the adolescent years. Fifty-one adopters were receiving support at the time of the inspection, with over £250,000 secured from the adoption support fund. Adopters told inspectors that adoption support had prevented breakdowns, particularly when their teenage children were displaying aggressive behaviour at home.

90. Adoption social workers complete the majority of child permanence reports, and this concentration of expertise results in a consistently high standard of reporting. Skilful reporting of children's personalities, births, early childhood development and family histories provides potential adopters with detailed, rich and informed portraits of young children awaiting adoption. Reports offer clear explanations of why adoption is the most appropriate permanent legal option for children. Life-story books are also prepared within the adoption team, resulting in colourful, engaging and child-friendly accounts of children's journeys towards their adoptive families which can be updated by adopters. Therapeutic life-story work is provided to older children who are struggling to understand their birth family histories and identities.

91. Active family finding occurs through regular meetings and action planning concerning individual children. Prompt referrals are made to Link Maker, the adoption register and the South West adoption consortium. Current regional collaboration is evolving further through the formation of Adoption West, involving six local authorities, scheduled to become operational in April 2018. It is anticipated that adopter recruitment, assessment, family finding and panels will be regionalised, providing a larger pool of adopters to offer permanent families to children from a broader range of ages and those with more complex, specialist needs.

92. A long-standing, highly regarded adoption panel chair with an extensive professional background in adoption work chairs the adoption panel. Panel members closely examine reports prior to meetings, devising incisive and pertinent questions for social workers and potential adopters concerning matches, approvals and disruptions. The adoption panel chair receives a thorough annual appraisal from the head of service. The panel comprises an experienced blend of professional and lay members. All panel members are appraised annually by the adoption panel chair, and attend training and development events at least twice a year.

93. Panel minutes are detailed and well written. The timeliness of decisions following the agency decision maker's (ADM's) review of panel recommendations improved significantly after a challenge from the panel chair. Subsequently, the head of service promptly completed all approvals. The ADM carefully and concisely documents the reasons for decisions, evidencing close reading of all relevant reports.

94. The previous backlog in letterbox contact arrangements has been addressed and all recommended contact agreements are well supported, with advice offered to birth and adoptive families about appropriate contact. Post-adoption social workers provide informed advice to adopters concerning the growing numbers of children who have unplanned contact with birth families through social media. Stringent efforts to ensure that appropriate contact is maintained with brothers and sisters are made when this is in children's best interests.

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

95. Social workers and personal advisers in the transitions to independence team, the care leavers' service, are in regular contact with 97% of care leavers, and know their situations well. They visit young people frequently and meet with them at convenient locations. However, care leavers say that they would also like somewhere to meet or to drop into, because the office where the team is based is not conducive to young people visiting.

96. Care leavers report that they have strong and positive relationships with their personal advisers, who provide genuine care and support, and know their needs. This proactive and caring approach to remaining meaningfully involved in young people's lives was evident on case files. The commitment and practical help from their personal advisers enable care leavers to cope with personal difficulties. Personal advisors give sound financial advice and

effective assistance with travel and accommodation. They provide sensitive and helpful advocacy and support, such as helping young people who are in difficulty because of offending, accommodation problems or debt crisis.

97. Care leavers feel safe and, overall, personal advisers offer helpful guidance to young people about keeping themselves safe. For example, inspectors saw proactive work with a young woman to protect her from the risks of an abusive relationship, while encouraging her to accept help to make positive choices about her future. Personal advisers engage well with care leavers in discussing the nature and types of risky behaviours. However, managers and staff have not sufficiently considered the risks relating to child sexual exploitation that care leavers may face. Reviews and plans do not include proper attention to these risks, although appropriate protocols are in place. A relatively small proportion of staff in the transitions to independence team have received child sexual exploitation training. Managers have already put plans in place to increase staff knowledge and skills within the service. (Recommendation)

98. Personal advisers do not always engage care leavers sufficiently in the process of pathway planning. Pathway plans do not sufficiently prepare care leavers for their next steps and they are not used effectively to help young people to develop the skills and qualities that they will need to be independent. Plans are up to date, but they do not fully assess the needs of care leavers to enable effective planning. Planned outcomes are often too vague, stating, for example, the need for a young person to understand the benefits system. They do not lead to clearly defined actions to be taken that will lead to specific results and a tangible sense of achievement for the young person. (Recommendation)

99. Personal advisers and social workers do not always pay enough attention to planning for longer-term outcomes, particularly in relation to helping care leavers to improve their educational and employment prospects. The recording of care leavers' educational attainments is not consistently accurate or detailed enough for each young person, resulting in incomplete information about their starting points and fragility in ensuring appropriate goals for care leavers to work towards.

100. Outcomes for care leavers are variable. For example, compared with other young people who live in South Gloucestershire, too high a proportion of care leavers do not engage in education, employment or training for too long a period of time, although the percentage decreased from 43.5% in March 2015 to 32% in December 2016. A significant proportion of care leavers, numbering 32, are not available to take an active part through illness, medical conditions, disability or parenting responsibilities. Through the virtual college and two

recently appointed education, employment and training workers, closer links are being made with the local further education college to provide suitable courses for care leavers to enable them to acquire the skills and knowledge to gain employment or progress in education. (Recommendation)

101. Currently, 11 former care leavers are studying in higher education. The local authority is actively supporting one former care leaver who is studying for a Master's degree. The support that these care leavers receive to make a success of their studies is regular and helpful.

102. Care leavers do not possess sufficient knowledge about their entitlements as care leavers and do not receive important information regularly enough. This was confirmed in discussion between inspectors and young people. Young people are provided with their health histories, but the quality of the information received varies between personal advisers and individual young people. (Recommendation)

103. Personal advisers ensure that care leavers receive appropriate and prompt medical and health attention. Young people benefit from annual health assessments with the dedicated paediatrician and from helpful support by the designated nurse.

104. Help through the family nurse partnership nurse is effective for young parents or those who are pregnant. A newly appointed transitions worker for young people with mental health concerns is now providing additional valuable support.

105. Care leavers receive good help to find suitable accommodation, and this is also the case for those with complex needs. Appropriate checks are carried out to ensure the accommodation is of good quality and safe, and that young people feel secure. They have access to a good range of relevant housing, including tenancies in safe neighbourhoods.

106. No care leaver is currently in accommodation deemed as unsuitable although, at the time of inspection, three young people were in custody. No care leavers were placed in temporary emergency or bed and breakfast accommodation. The 'staying put' strategy is working well for care leavers. Currently, 12 young people are benefiting from the arrangements and staying with their foster carers.

107. An awards ceremony organised by the Children in Care Council celebrates the achievements of care leavers positively, with certificates awarded to each young person. It is working with young people to review the event and ensure greater involvement of care leavers at future events.

108. Care leavers enjoy access to and support for different recreational activities, such as going to the gym, basketball and cycling. They receive financial help to participate if they need this, or to develop their skills or interests further.

109. Managers know the strengths and weaknesses of the service and have well-considered plans in place to bring about the required improvements that they have identified. They are taking appropriate action to enable care leavers to become independent and self-reliant and secure employment or training, but the impact of these actions is not yet evident in all areas.

Leadership, management and governance	**Inadequate**

Summary

The leadership, management and governance of services for children who need help and protection are inadequate. Political leaders and senior managers have not demonstrated sufficient understanding of the extent of the widespread and serious failures within the service, in particular in the 0–25s disability team. Some practice has improved as a result of recent targeted activity but, over the longer term, leaders have not made sufficient changes quickly enough to address the deficits, leaving too many children vulnerable or at risk of harm.

Leaders and managers have not ensured that some elements of core social work practice are sufficiently robust. For instance, child protection thresholds are not consistently applied and not all children who need an early help assessment benefit from one.

More recently, over the past year, the head of service has implemented service-led self-assessments and plans, resulting in a sharper focus on what needs to change. However, performance management systems have not been effective enough to identify some key weaknesses in services for children. There is no overarching service plan incorporating learning and actions from quality assurance activity. Case auditing is embedded in practice, but findings are not always used to improve wider practice. Data is collated and analysed, helping key groups such as the corporate parenting board to interrogate practice, but weaknesses in the client record system limit the collection of data and hamper the recording of work with families. The impact of the provision of early help on children and families is not fully understood.

Strategic arrangements to respond to child sexual exploitation have improved, but managers have not ensured that a clear child-level process is in place to respond to risk. Corporate parenting arrangements work well, although the Children in Care

Council needs to be strengthened. The quality of management oversight and staff supervision, including appraisal, varies too much across teams.

Social workers are proud to work in South Gloucestershire and feel well supported by visible managers. Learning and development for practitioners is strong. A comprehensive programme to develop the skills of operational managers has been well received. Strategies to stabilise the workforce are becoming increasingly effective, assisted by strong political support. However, in some teams, such as the 0–25s disability service, agency rates remain too high.

110. The local authority has recognised that there have been serious and widespread weaknesses within children's services. Determined to address the decline in service provision, the director of children's services (DCS) established a 'turnaround' board. Operating from October 2014 to January 2016, the board provided greater oversight of children's services. Significant improvements in some areas of children's services gave the board confidence to re-establish itself as a children's services governance board. The board oversaw the restructure of children's services and the reorganisation of early help provision. Senior management oversight has been strengthened through the appointment of a new head of integrated services. The head of service has been in post for a year and has filled a vacuum by providing stable, consistent and visible leadership, with a clear vision of how services for children need to be improved.

111. While the majority of service managers have remained constant, there has been significant churn at team-manager level and a high level of use of agency staff that have seriously slowed progress and limited oversight in some parts of the service, in particular the 0–25 disability service. Concerns were identified at a senior level and a decision was made to transfer the 0–25s disability service from adult services to children's services. Senior managers established a turnaround board specifically for this service, developing plans to address the significant shortfalls identified in the service. However, senior and political leaders have not taken sufficient steps to interrogate the performance data available to establish the true extent of the shortfalls, including the number of unallocated cases in the service and their impact on children and families. Actions have not been targeted or urgent enough to achieve the substantial changes that were necessary. This has resulted in a large number of vulnerable children not receiving the help, support and protection that they need. In some cases, risk remained unassessed. (Recommendation)

112. The quality assurance framework is due to be refreshed by the recently appointed principal social worker. Team managers have been engaged in its

design, which is positive. Regular themed case auditing takes place, and this is used to some extent to inform practice. However, there is no overarching plan that incorporates the learning and actions from the range of quality assurance activity that takes place on a regular basis. Senior managers also recognise that more work needs to be done to support social workers in understanding what good practice looks like, to ensure that there is a greater degree of consistency in casework. A new consultant social worker post, commencing early in 2017, will focus on this work. The planned changes are not yet evident, and current quality assurance processes have not been robust enough to ensure that managers and leaders have a clear enough view of practice or service weaknesses, such as in the 0–25s disability service. (Recommendation)

113. Since her appointment, the head of service has put in place strategies to improve managers' understanding and ownership of the performance of their service areas. These have included one-to-one work with managers and business support by the performance data team. All performance reports use a consistent dataset that is widely circulated to managers, and the narrative behind the performance data has improved. The head of service provides bi-monthly performance reports to the scrutiny panel. The lead member and chief executive told inspectors that they are now better informed about children's services, and consequently they can better scrutinise performance across the service and support senior managers when they can see a decline in performance.

114. Service plans are inconsistent in quality and focus. Reports are taken to the monthly governance board, chaired by the DCS. The development of plans by each service manager is an important shift in ensuring that service improvement is owned and managed by all managers. However, not all plans are SMART (specific, measurable, attainable, realistic and timely), and reports are lengthy and insufficiently focused on key priorities. (Recommendation)

115. More work needs to be done to ensure that measures are in place to understand performance in some areas of the service. For example, the authority does not currently know how many children looked after attend their reviews. The authority has not analysed the overall impact of early help services, and service developments are not clearly enough linked to the evaluation of the difference that support makes to local families. Although the new client record system, when it is introduced, will include an integrated evaluation tool, senior managers and partners need to understand the impact that services are having on outcomes for children now. (Recommendation)

116. Governance arrangements are clear, and are delivered through a committee structure and scrutiny panel. Well-established formal and informal contact

between the chief executive, DCS and lead member, and with the LSCB chair prior to her recent departure, assists communication and challenge. Committee arrangements have provided helpful scrutiny in some areas, for example in exploring agency and out-of-area placement spending. However, while regular performance reports have been provided to the children and adults committee, including those of the 0–25s service, challenge to officers has not been effective enough to identify and address concerns successfully.

117. Political and corporate leaders are committed to ensuring that there is adequate funding for children's services, with substantial additional financial investment in recent years. The base budget for children's services has been increased to reflect demand and the need to address service weaknesses. Regular reports keep members informed of the pressures on services and the reasons for any overspend. In the context of financial constraints, this means that children's services have continued to receive the required financial resources.

118. A variety of commissioning arrangements are in place to ensure that services are available to meet the needs of children. Services are commissioned based on identified need, informed by the joint strategic needs assessment and by relevant needs analyses undertaken by partners. Commissioned services are regularly reviewed against key performance indicators, and measures are swiftly taken to address shortfalls. Provider and user consultation feeds into service specifications. Following a needs analysis, services for domestic abuse are being recommissioned through partnership arrangements.

119. Appropriate commissioning strategies are in place to ensure that there is a range of placements to meet the needs of the children looked after. For example, underneath the overarching commissioning strategy there is a number of focused plans to address particular needs, based on careful analysis of domestic abuse, for example. Although targets are overly optimistic, the authority has plans in place to increase the number of foster carers and recognises that this is a priority.

120. Social workers speak positively about working in South Gloucestershire, and almost all told inspectors that they feel well supported by managers. However, management decisions and formal supervision are variable in frequency and quality. The supervision policy, which is due to be updated, does not include expectations about the frequency of case supervision. No system is in place to monitor the completion of annual appraisals. (Recommendation)

121. Caseloads remain variable across the service and there is no policy document that outlines the authority's expectations for caseloads, including whether it is acceptable for cases to be allocated to managers. Senior managers have taken

action to address the high caseloads within the access and response team (ART), and have put into place plans to increase the team establishment. At the time of the inspection, caseloads in the ART were at an average of 33. The majority of social workers in other teams have manageable caseloads, with a small number of exceptions. Measures to oversee and manage caseloads have not placed sufficient gravity on unacceptably high caseloads, such as those found within the 0–25s disabilities service. At the time of the inspection, this included six children looked after who had been allocated to managers. (Recommendation)

122. Strategies to stabilise the workforce are proving to be effective, with a steady decrease in turnover. Turnover was 27% in 2014–15, decreasing to 24% during 2015–16. The proportion of permanent staff is increasing. In March 2015, 49.9 agency staff were employed by the service, falling to 22.3 in September 2016. Comprehensive monthly data provides senior managers with a clear understanding of turnover, agency use and sickness levels within each team. Despite this focus, agency rates have remained high in some parts of the services such as the ART and the 0–25s disability team. While there are now plans in place to increase the establishment of ART, some children have experienced too many changes of social worker. Within the 0–25s team, high staff turnover and the high number of temporary staff have contributed to the widespread and serious failings within the service. While senior managers are able to articulate priority areas, the action plan to support the workforce development strategy is not robust. This means that there are no clear targets and timeframes to ensure that plans are effectively progressed.

123. The authority has been effective in increasing the recruitment of assessed year in practice (ASYE) social workers and 'Step Up to Social Work' students. ASYEs are well supported, with protected caseloads and regular learning and development opportunities. Strategies to aid workforce retention include progression opportunities for social workers to advance a grade if they meet expected standards. A pilot programme is in place to support social work assistants to study for a social work qualification with the Open University. The authority uses intelligence from exit interviews to inform recruitment processes, and this includes a telephone interview with agency staff.

124. Senior managers are committed to ensuring that the workforce is appropriately trained and that professional development opportunities are well resourced. Over the past 18 months, managers have prioritised a whole-system approach to delivering the local authority's chosen approach to assessment. Social workers and partners spoke positively about how this is improving practice. This is a considerable financial investment and demonstrates a firm commitment to improving practice. In response to the identification of inconsistency within management oversight through case

auditing, senior managers have commissioned a comprehensive training and development programme for all managers, commencing during the inspection. This is a positive initiative.

125. While there is clear commitment to training and development, the needs of the workforce are not fully understood. In some areas, training to support social workers in their role had not been in place. For example, only 11% of staff in the leaving care service are trained in understanding child sexual exploitation. A learning needs analysis is being undertaken which will inform next year's training schedule, but this has not yet taken effect. The impact of training and development on practice is not fully understood. For example, although managers monitor the use of research library licences, the effect on practice has not been assessed. Following the introduction of a new practice model of assessment, senior managers have clear plans in place to understand what difference this approach makes. (Recommendation)

126. Political and senior managers take their corporate parenting responsibilities seriously, and this is a strong aspect of the service. All council members are appropriately trained and those who spoke to inspectors expressed a firm commitment to improving outcomes for children looked after and care leavers. Newly commissioned council contracts include clauses to ensure that they provide work experience for children looked after and apprenticeships for care leavers. Council members provide effective challenge, for example regarding housing provision for care leavers. A 'You said, we did' video of responses to questions from the Children in Care Council ensures that there is a method in place for regular representation of children's views to the corporate parenting group.

127. The local authority has established constructive relationships with the local family justice board and the Children and Family Court Advisory and Support Service (Cafcass). The judiciary and Cafcass are positive about the quality and timeliness of work presented by the local authority in court.

128. Steps are being taken along with partner agencies to strengthen the strategic response to children at risk of sexual exploitation. However, practice in relation to individual children is inconsistent, and senior managers and partners have not yet established a coherent multi-agency process for understanding patterns and trends in relation to victims. Further work is needed to tackle these deficits on a number of levels, including the provision of direct support, ensuring the consistent application of child protection thresholds and that the multi-agency workforce is appropriately skilled to undertake this work, and strengthening management oversight. (Recommendation)

129. There has been no formal test of assurance undertaken since the director of children, adults and health took up his role in 2013. Although the chief executive regularly discusses capacity issues with the DCS, the absence of this formal test means that the local authority cannot be fully assured that the breadth of the role is appropriate, or that the senior leadership team has sufficient capacity to lead the changes required in children's services.

130. Change for individual children takes place as a result of complaints, and the complaints team has established helpful links with the advocacy service and the Children in Care Council. However, a system is not in place to ensure that wider learning informs future practice. The high number of complaints from parents and professionals for children with disabilities further evidences the need to ensure that a robust learning and improvement system is in place to inform the improvements required across the service. (Recommendation)

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is inadequate

Executive summary

The South Gloucestershire Safeguarding Children Board is inadequate, because it has not established effective arrangements to meet its statutory responsibilities as outlined in 'Working Together 2015'. In particular, it has not sufficiently monitored and evaluated the effectiveness of frontline services. The board has not been able properly to challenge or influence key areas of local safeguarding practice.

The board is leading the overall strategic approach to child sexual exploitation and has updated the child sexual exploitation strategy, guidance and risk assessment framework. However, it was not aware that child protection procedures for children at risk of child sexual exploitation are not always being followed. The board has not sufficiently challenged or influenced practice weaknesses in relation to the identification of significant harm for children.

The board has received an appropriate range of reports about frontline practice. However, it has not been sufficiently rigorous in ensuring that required actions are taken when concerns are identified. For example, the board did not have sufficient knowledge of the serious and widespread failings that inspectors found in the 0–25s disability service. Weaknesses in assessing and overseeing private fostering arrangements have not been sufficiently challenged by the board.

Updates have been provided to the board about the development of early help services, and the board has appropriately challenged health services about their lack of contribution to early help assessments. However, the board has not ensured that the effectiveness of early help has been properly evaluated.

The board has not had any oversight of the safeguarding practices of the mother and baby unit at the local prison, and therefore cannot assure itself that the welfare of the babies and children who live there is safeguarded and promoted.

The effectiveness of the board's multi-agency dataset has been reduced, because it does not include sufficient data about the core business of child protection to enable the board to scrutinise frontline practice. As a result, the board has not been able to scrutinise themes or trends over time or use this data to challenge the local authority's safeguarding practice.

The board's annual report adequately describes work undertaken during the year, but it does not provide a sufficiently rigorous analysis of the effectiveness of local safeguarding practice or evaluate the progress made in completing the previous year's priorities.

Recommendations

131. Provide clear guidance to staff about the procedures and processes to be used when children and young people are at risk of significant harm due to child sexual exploitation.

132. Provide robust oversight and scrutiny of practice in relation to the 0–25s disability service.

133. Ensure that the effectiveness of early help services is properly evaluated.

134. Establish links with Eastwood Park Prison mother and baby unit to ensure that these babies are safeguarded and that their welfare is promoted.

135. Further review the multi-agency dataset to ensure that it contains sufficient information to judge the effectiveness of services, particularly in relation to child protection practice.

136. Increase challenge and scrutiny of practice relating to children who are privately fostered.

137. Ensure that the processes of the board are rigorous, that actions agreed are monitored and that priorities are evaluated for their impact on outcomes for children.

138. Strengthen the usefulness of the annual report by more closely evaluating what the board has achieved against its key priorities.

139. Scrutinise multi-agency understanding of female genital mutilation, including how agencies should respond in cases when it is suspected, and to ensure that advice and expertise is available.

Inspection findings

140. The South Gloucestershire Safeguarding Children Board (SGSCB) is inadequate. It has failed to provide sufficient leadership to identify, monitor and challenge the widespread and serious failings identified during the inspection.

141. The independent chair of the SGSCB resigned before the inspection. The director of children's services (DCS) is now holding the position on a temporary basis until a new chair is appointed. The DCS, lead member and

other board members acknowledge that renewed focus, rigour and scrutiny are required to enable the board to fulfil its statutory responsibilities and satisfy itself that all agencies across the partnership are keeping children safe.

142. A wide range of multi-agency reports are submitted to the board. These cover key areas of core business, but not all board members have exercised sufficient curiosity about the information presented. For example, in September 2015 the board challenged the quality of a report about safeguarding children with disabilities, and appropriately requested that it be reviewed and re-presented to the board. The board did not then ensure that the report was returned in a timely way and hence did not know about the widespread and serious weakness within the children's social care 0–25s disability service.

143. The board has exercised appropriate oversight of strategic arrangements to understand the level and nature of local child sexual exploitation. However, the board has not taken sufficient steps to provide clear procedural and practice guidance for local professionals, particularly in identifying and responding to significant harm for children at risk of sexual exploitation.

144. The board has reviewed the child sexual exploitation guidance and improved the risk assessment tool by including a section on perpetrators. Through a multi-agency project, a problem profile has been undertaken and shared in order to aid identification and disruption. Extensive awareness raising and training have been provided, funded by the board, to those who work in the night-time economy and leisure industry, and to local professionals who work with children.

145. The child sexual exploitation sub-group discussed the interface between child sexual exploitation and child protection in January 2016, but did not reach a conclusion. Guidance remains ambiguous and, as a result, partners and frontline practitioners are unclear about the steps needed to analyse and address these risks. Further, the board has not ensured that it has sufficient oversight of the wider inconsistencies in the application of child protection thresholds for children at risk of significant harm. (Recommendation)

146. Members of the sub-group against child sexual exploitation acknowledge that a clear risk assessment pathway is needed. This has been formulated and agreed but not yet implemented, therefore has not yet affected frontline practice. This will consider individual children, but will not address the need for coordinated multi-agency oversight of all children, including those considered to be at medium or high risk of sexual exploitation. This is a missed opportunity to identify patterns, trends and links between children who are at risk and the places where they spend their time. (Recommendation)

147. The board receives progress reports about early help and has challenged health partners about their lack of engagement in early help assessments. However, the board has not ensured that the effectiveness of early help is sufficiently evaluated to make sure that services are targeted and meet the identified needs of children and families. (Recommendation)

148. Identifying private fostering arrangements remains a challenge for the local authority. The private fostering annual report is comprehensive, but board members have not sufficiently scrutinised practice in this area to promote timely assessments and visits to children. (Recommendation)

149. Despite its efforts, the SGSCB has been unable to ensure the effective engagement of the local women's prison in the work of the board. As a result, there has been no monitoring of safeguarding practice within the prison's mother and baby unit, and the quality of work to safeguard the 13 babies and children who are resident within the prison is therefore not known by the board. (Recommendation)

150. A quarterly multi-agency dataset updates the board on safeguarding performance across agencies. To increase its usefulness, board members have regularly reviewed the content and structure of the report. However, the dataset still does not provide sufficient information to enable the board to judge the effectiveness of local child protection practice. For example, it identifies timescales for initial child protection case conferences, but not the number of child protection enquiries that do not result in a conference. This limits its effectiveness. (Recommendation)

151. A good range, but very small sample (four cases) of multi-agency audits are undertaken on behalf of the board, providing a sound analysis of practice in narrative form. However, audits lack overall judgements about the quality of work and do not have SMART (specific, measurable, attainable, realistic and timely) action plans to monitor and evidence progress against actions. For example, a recent multi-agency audit of four missing children did not include children looked after and, while some findings were helpful, it did not identify that none of the cases were compliant with procedures. Actions did not address all areas of weakness. The previous chair requested that single-agency audits are presented to the board, but agencies have been slow to respond. This has reduced the effectiveness of the board to monitor local safeguarding practice. (Recommendation)

152. The priorities of the SGSCB were agreed following a multi-agency workshop and are described in the board's annual business plan. Overall, priorities are sound and are relevant to the local area. The board's priorities have

influenced the joint strategic needs assessment, which now has information about child sexual exploitation and female genital mutilation in a safeguarding chapter. However, the intended outcomes are unclear, and this means that actions arising from the priorities are mainly process steps. They are unlikely to enable the board to measure its success in scrutinising and influencing local safeguarding practice.

153. The board is appropriately constituted, with wide membership including two lay members. Lay members contribute well to the board's work. An executive group sets the agenda for the board and drives its work programme. It is a strength that the nine sub-groups are chaired by partners, for example the clinical commissioning group, the voluntary sector and the local authority. Most of the sub-groups are well-attended and, when this is not the case, the board robustly challenges the agency concerned. The board has discussed financial contributions, resulting in the identification of additional funding for the appointment of a board manager. However, the budget for 2017–18, with the respective contribution of partners such as the police, has yet to be agreed.

154. Sub-groups have undertaken a considerable amount of work, but they do not all have SMART action plans that interpret and are aligned to the boards' priorities. The previous independent chair requested that all sub-groups submit their plans to the board for agreement. However, this has not happened in all cases. The board therefore does not have robust oversight of the work of all sub-groups and is unable to agree or influence their priorities. For example, the policy and procedures sub-group has not identified that the local authority protocol for assessment, which should set out clear arrangements for how children will be assessed by children's social care, has not been considered by the board. As a result, the protocol is significantly delayed. (Recommendation)

155. Governance arrangements with the local authority are in place, but have not been consistently effective in highlighting service weaknesses. The previous chair met regularly with a range of partners, including the chief executive, DCS, leader of the council and lead member for children's services. The chief executive has observed a board meeting. Some board members have recognised that the board has lacked focus, rigour and analysis and, through the governance process, have taken appropriate steps to address this.

156. The chair of the board attends the children, young people and families partnership. Cross membership of the Health and Wellbeing Board and the 'Safer and Stronger' partnership ensures that information is shared and exchanged. The board has ensured that these strategic bodies adopt their

priorities. For example, domestic abuse is a shared priority. A multi-agency domestic abuse conference is due to take place in spring 2017.

157. Procedures for dealing with female genital mutilation are up to date, and the board has provided awareness-raising training. Strong links with the local acute trust, which is a centre of excellence, are in place. While few cases of female genital mutilation have been identified, inspectors were satisfied that social care staff are alert to the issues and could deal with them appropriately. However, one case highlighted partnership issues between the police and health professionals. Practice requires further analysis by the board to identify any threshold or training issues. (Recommendation)

158. Local professionals, including school staff, have received training in identifying children and young people at risk of radicalisation. The head of safeguarding is a member of the council's steering group for 'Prevent'. A range of agencies refer to the 'Channel' panel, although none have met the threshold for discussion in this forum. Screening by the head of safeguarding ensures that vulnerable children who are referred receive appropriate services. Schools have access to appropriate resources to support them in their 'Prevent' duty.

159. The child death overview panel (CDOP) identifies effectively the learning arising from child deaths. The annual report is thorough and analytical, identifying learning for the board. The CDOP has taken action at a local, regional and national level to drive changes, for example by lobbying ministers about the importance of personal health and social education to help children to understand safeguarding risks.

160. Effective challenges to agencies have resulted in improved practice. The board has been instrumental in the police reconsidering their initial position that they would only be part of a virtual multi-agency safeguarding hub (MASH). Although these discussions have contributed to some delay, they have ensured that the newly proposed model of a co-located service will be more appropriate to local practice. The process has also facilitated an agreement to provide health resources to the MASH.

161. After a slow start, progress is being made in meeting the requirements of national guidance for missing children through the scrutiny of the 'missing' sub-group. Timeliness of return home interviews is now monitored to support improvement. A spreadsheet detailing 'missing' incidents and return home interviews supports the monitoring of timeliness. The list is appropriately cross-referenced with children who are at risk of sexual exploitation. This analysis prompted an appropriate multi-agency response to a local independent children's home at which child sexual exploitation was identified.

162. The board has updated and widely distributed its threshold document. Cases seen during the inspection evidenced that, overall, thresholds for referral to children's social care are appropriately understood and applied.

163. The board ensures that learning from serious case reviews improves practice. For example, the involvement of fathers in assessments, plans and decisions about their children has improved significantly. The board's protocol on non-mobile babies has been adopted across the region, and audits undertaken by health partners evidence knowledge and understanding of the protocol. The board has undertaken a range of in-depth learning reviews involving practitioners, leading to improvements in safeguarding practice. Findings are widely shared. Learning from these reviews includes improvements in the management of allegations against professionals who work with children. Further capacity has been added to the designated officer role.

164. Partners undertake section 11 audits, including themed audits for training and child sexual exploitation, on a regional basis. Following robust challenge by the board, all agencies returned their audits. These have been analysed, with themes feeding into the child sexual exploitation and training sub-group action plans. All schools responded to their annual section 175 audit. Further changes have been made in order to increase rigour in self-assessment and to ensure greater attention to the board's priority areas, such as female genital mutilation and child sexual exploitation.

165. The board has made progress in implementing the learning and improvement framework. A training strategy is in place, outlining the training required for each role. All LSCB trainers are quality assured by the board. Lay members speak to delegates and their managers post-course to assist in the evaluation of impact. Delegates value the training that they receive. However, a training needs analysis has been designed yet has not yet been undertaken. This has reduced the board's ability to target training at specific professionals or agencies.

166. Overall, the board's annual report is compliant with the guidance in 'Working Together 2015'. It references the required areas and provides a detailed narrative of the work undertaken by sub-groups. However, the report is not sufficiently analytical. It does not evaluate the progress made in implementing the previous year's priorities or analyse the effectiveness of local safeguarding practice sufficiently. This weakens the potential impact of the report in informing partners about strengths and areas for development. It has not informed the priorities for the forthcoming year.

167. The board is making good progress in listening and responding to the voice of children and young people, and has involved the youth board in reviewing the

missing children protocol and responding to the pupil survey about e-safety. The youth board did not think that many young people would read leaflets and wanted a more proactive approach to explaining risks. This has had a positive impact: more schools access safeguarding assemblies, and youth workers receive helpful support in addressing e-safety concerns.

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

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

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

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

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

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