Telford and Wrekin Council

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

and

Review of the effectiveness of the Local Safeguarding Children Board[1]

Inspection date: 13 June 2016 to 7 July 2016

Report published: 26 August 2016

Children's services in Telford and Wrekin require improvement to be good		
1. Children who need help and protection		Requires improvement
2. Children looked after and achieving permanence		Requires improvement
	2.1 Adoption performance	Good
	2.2 Experiences and progress of care leavers	Good
3. Leadership, management and governance		Requires improvement

[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

The director of children's services (DCS) and his senior team have made some important improvements in the quality of services and in the outcomes that children are achieving. The appointments of the DCS and the assistant director for safeguarding, in January 2016 and September 2015 respectively, have been a particular catalyst for accelerating ongoing improvement work. This progress is helped by effective political backing and the hands-on support of the managing director. However, services are not consistently good. This is because some developments are too new to have made a significant difference, others are not yet in place and gaps remain in the consistency and quality of first-line management oversight and scrutiny.

Children and young people are kept safe by the work of the local authority. It acts quickly and effectively to protect them when they are at immediate risk of significant harm. However, although acute risks are identified and responded to swiftly, chronic risks are not always identified or responded to as quickly. As a result, some children experience delay in receiving help or coming into care. The local authority is aware of this and is working to improve practice. For example through its focus on identifying and tackling the impact of neglect on children and young people. However, a few children still enter care in an emergency, rather than in a planned way, even when these concerns are already known to the local authority.

The majority of social workers receive regular supervision and management oversight. When this is supported by the reflective 'pods' approach, the quality of supervision is generally good and has a sharp focus on the wishes and feelings of children. However, gaps remain in the quality and frequency of the supervision, case direction and oversight. Where such gaps exist, they lead to delays in progressing work and improving outcomes for some children. Social workers know children and young people well. They are committed to achieving positive outcomes for them. The local authority has worked hard to ensure that almost all social workers have manageable caseloads. It has increased workforce stability and reduced reliance on temporary agency staff. This means that social workers are able to visit children and young people regularly and build good relationships with them.

Performance management and quality assurance systems provide a largely accurate picture of performance. However, they are not being fully used to drive up standards. This is because measures being monitored are not always updated to reflect changing or new priorities and this work is not informed by feedback from children and their families. The independent reviewing officer (IRO) service is not providing enough scrutiny and drive in planning for children looked after and those subject to child protection plans. It does not have a clear overview of service performance. Caseloads in this service are significantly above statutory guidance. This reduces its effectiveness. Work to identify children and young people who are privately fostered and to assess their welfare is not fit for purpose.

The early help offer provides a broad range of services for children and families in

Telford and Wrekin. The multi-agency safeguarding hub (MASH), known as Family Connect, provides an effective single point of contact and a swift response to risk. Work with children and young people at risk of sexual exploitation is very strong. The local authority has been a champion for tackling this issue. It provides leadership to partner agencies, with who this work is well-coordinated. Work to protect children who go missing from home or care is thorough and improving. However, return home interviews are not always carried out in good time.

The quality of assessments is variable. While those for children looked after are better, most are not good overall. Assessments usually include an account of children's past history but this is not always analysed effectively or used to determine future risk. The views of children, although recorded, are not always well used to understand their experience or to inform planning. The majority of plans lack sufficient clarity. They are not always clear about who is expected to do what and by when. This can be confusing for families and professionals, making it difficult to measure progress. Strategy meetings do not always include agencies, other than the police. This sometimes limits information available to inform decision-making. Children looked after are not always placed under the legal status that best ensures their welfare. Placements under section 20 of the Children Act 1989 and placement with parents regulations are not always used appropriately or effectively. The local authority is reviewing its use of section 20 but this work is not complete. Advocacy is not used often enough to help children or young people to be more involved in meetings about them. The provision of independent visitors is limited.

As a corporate parent, the local authority is improving health and education outcomes and increasing placement stability for children looked after. However, it has not managed to recruit a sufficient number and range of foster carers to provide suitable placements for all the children who need them. Also, housing options for care leavers and homeless young people are not consistently meeting need. The local authority is working hard to address this deficit. It uses independent fostering agency placements to limit the negative impact of this shortfall, but more work needs to be done. The Children in Care Council, 'Voice', is effective. It engages well with, and listens to, children looked after. The DCS and lead member are regular attendees. A detailed and helpful 'pledge' document has been produced, with the help of 'Voice'. However, this is not used as well as it could be to help children and young people be aware of their rights and entitlements.

Children who could benefit from adoption are identified early, well matched and swiftly placed with adopters who receive good support. However, fostering to adopt is not currently used and this is a gap. Permanence planning is significantly weaker for those who achieve permanence through options other than adoption. This includes those in long-term foster care or who return to their birth families. Permanence is not routinely considered at children and young people's second looked after reviews.

Care leavers get good, timely support from skilled and experienced social workers and personal advisers. This helps them make successful transitions to adulthood.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates no children's homes.
- The previous inspection of the local authority's safeguarding arrangements was in August 2012. It was judged to be adequate.
- The previous inspection of the local authority's services for children looked after was in August 2012. It was judged to be adequate.

Local leadership

- The director of children's services (DCS) has been in post since January 2016.
- The DCS is also responsible for adult services.
- The chair of the LSCB has been in post since January 2013.

Children living in this area

- Approximately 39,010 children and young people under the age of 18 years live in Telford and Wrekin. This is 23% of the total population in the area.
- Approximately 23% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 17% (the national average is 16%)
  - in secondary schools is 15% (the national average is 14%).
- Children and young people from minority ethnic groups account for 12% of all children living in the area, compared with 22% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Asian or Asian British and Mixed.
- The proportion of children and young people who speak English as an additional language:
  - in primary schools is 9% (the national average is 19%)
  - in secondary schools is 7% (the national average is 15%).

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

Child protection in this area

- At 31 March 2016, 1,266 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 1,112 at 31 March 2015.
- At 31 March 2016, 190 children and young people were the subject of a child protection plan. This is an increase from 103 at 31 March 2015.
- At 31 March 2016, six children lived in a privately arranged fostering placement. This is an increase from three at 31 March 2015.
- Since the last inspection, five serious incident notifications have been submitted to Ofsted and four serious case reviews have been completed or were ongoing at the time of the inspection.

Children looked after in this area

- At 31 March 2016, 299 children were being looked after by the local authority (a rate of 77 per 10,000 children). This is an increase from 295 (75 per 10,000 children) at 31 March 2015. Of this number:
  - 124 (or 42%) live outside the local authority area
  - 35 live in residential children's homes. Of this 35, 51% live outside the authority area
  - one lives in a residential special school[3] outside the local authority area
  - 223 live with foster families. Of these, 39% live outside the authority area
  - 14 live with parents. Of this 14, 7% live outside the authority area
  - none are unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been 15 adoptions
  - 22 children became subject to special guardianship orders
  - 109 children ceased to be looked after. Of this 109, 5% subsequently returned to be looked after
  - eight young people ceased to be looked after and moved on to independent living
  - four young people ceased to be looked after and are now living in houses of multiple occupation.

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

Recommendations

1. Ensure that all social workers receive sufficiently regular and good quality supervision, oversight and direction from first-line managers to support consistently good practice.

2. Ensure that the IRO service provides sufficient scrutiny and drive to planning for children and young people. In particular, ensure that IRO's caseloads are in line with statutory guidance.

3. Develop further the effectiveness of performance management so that it is more responsive to new priorities as they emerge and takes into account feedback from children, young people and their families.

4. Support improved outcomes for children and young people by making sure that plans contain clear details, actions and timescales and are informed by timely assessments that contain clear analysis.

5. Ensure that an appropriate range of agencies are engaged and share information within child protection strategy discussions.

6. Improve work to identify children and young people who are privately fostered and assess their welfare, so that arrangements are fit for purpose and compliant with statutory guidance.

7. Ensure that return home interviews for children and young people who have been missing from home or care are all carried out in a timely manner.

8. Strengthen arrangements for supported and supervised contact, so that children looked after do not experience the cancellation of contact sessions due to a lack of resources.

9. Increase the availability of suitable housing, including emergency accommodation, for homeless 16- and 17-year-olds and care leavers.

10. Strengthen and speed up permanence planning for those children and young people who achieve permanence through routes other than adoption.

11. Ensure that that the support of an advocate or independent visitor is available for all children and young people who could benefit from this.

Summary for children and young people

- Most children and young people in Telford and Wrekin receive the right sort of help from the council when they need it. Social workers act quickly when children and young people are at risk so that they are safe. There are lots of different services that give good support to families to help them get over their difficulties.
- There are some parts of the service that could do better. When problems are not as urgent, the council is sometimes too slow in sorting out the right help. The council is working hard to get better at this but need to improve more. Assessments and plans need to be clearer so that everyone knows what has to change to make things better.
- Children only come into care when they need to. For a few children, this could happen earlier so that plans are not rushed.
- Children and young people live in good-quality placements. Social workers know children and young people well. They are good at listening to their wishes and feelings. Most children and young people who are getting help from social workers make good progress and have their needs met.
- It would be better if there was more choice of foster carers, so that brothers and sisters can always stay together when they first come into care. Planning could also be better so that the right decisions are always made as quickly as they could be.
- When adoption is the best plan for children, social workers work hard to make sure this happens quickly. They are good at finding the right families and helping them through any difficult times.
- Young people leaving care, including those who have a disability, are well supported. They have good practical support from personal advisers, who assist with things like appointments, managing money and encouraging access to education or employment. The main area that the council needs to get better at is ensuring that all care leavers have suitable accommodation, including being able to stay with their foster carers.
- Managers are working hard to improve services. They are doing this in lots of ways, such as by making sure there are enough social workers and managers who want to work in Telford and Wrekin. They also listen to the views of children and young people through the Children in Care Council, 'Voice', and the care leavers 'First' group. There is more work to do but they know about it and have a plan to improve.

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

Summary

The local authority acts quickly and effectively to protect children and young people when they are at immediate risk of significant harm. However, although acute risks are identified and responded to swiftly, chronic risks are not always identified or responded to as quickly. As a result, some children experience delay in receiving help and support. Inconsistency in the quality and frequency of management oversight contributes to this delay. The MASH, known as Family Connect, provides an effective single point of contact and a swift response to risk. However, focusing too much on pace limits the quality and range of information available to inform initial decision making about a few children. For example, strategy meetings do not always involve key partners, such as health services.

Families are able to work with a broad range of early help services to improve outcomes for children. This is because early help in Telford and Wrekin is strong. Work with children and young people at risk of sexual exploitation is good. It is well coordinated with partner agencies and this is improving outcomes for children.

The quality of most assessments still require improvement. Assessments usually include an account of children's past history but this is rarely analysed effectively or used to determine future risk. The voices of children, although recorded, are not always well used to understand their experience or to inform planning. The majority of plans, whether early help, child in need or child protection, lack sufficient clarity. They are not always clear about who is expected to do what and by when. This can be confusing for families and professionals. It can make it difficult to measure progress. This variability in the quality of assessments and plans is particularly evident for children in need, some of whom have experienced unnecessary delays in progressing their plans. Advocacy is very rarely used to help children be more involved in meetings about them.

For some specific groups of vulnerable children, services require strengthening. Children who go missing do not always receive a timely return home interview. When these do take place, the quality is variable. The local authority has used bed and breakfast accommodation for homeless 16- and 17-year-olds. Although only used for a very few young people, this is inappropriate. The process for securing longer-term housing has led to some vulnerable young people being placed in houses of multiple occupation without an adequate assessment of risk. Arrangements to ensure the welfare of privately fostered children are poor. The local authority is not currently meeting its statutory obligations for this vulnerable group.

Inspection findings

12. Family Connect provides an easily accessible single point of contact for all families and professionals seeking help and support. The service provides advice, guidance and access to both early help and statutory provision. This ensures that children and young people at immediate risk are quickly protected and that most children receive the right help at the right time. Thresholds are appropriate, well understood and well embedded in practice. As a consequence, there are very few contacts that result in no further action.

13. The early help offer is well supported by partner agencies. It offers a broad range of services and interventions to children and families. This leads to improved outcomes for children. The children and family locality service (CAFLs) provides help to coordinate universal and targeted services effectively. Early help teams are based in children's centres. This supports good partnership working and provides easy access for parents. It is further strengthened through local stakeholder groups.

14. The common assessment framework (CAF) is used with children and families in Telford and Wrekin, alongside a well embedded 'Team around the child' (TAC) approach. This helps prevent children's needs escalating to the point where statutory services are required. However, the quality of CAF assessments is not consistently good. Many lack clarity and are too focused on adult needs. This is particularly the case for those completed by agencies other than children's services. However, quality assurance arrangements are enabling managers to identify poorer assessments and target groups of professionals to improve quality. Effective step up and down arrangements are in place. These are supported through multi-agency meetings, with good communication and information sharing. This helps children and families receive a joined-up service.

15. Family Connect considers contacts effectively when more information is required to determine if statutory intervention is needed. The local authority sets itself an ambitious target of one day to deal with all contacts, including MASH checks and decision-making. As a result, children at immediate risk of significant harm are well protected through swift action. Multi-agency child enquiry (MACE) reports are used to request information from partners. In urgent situations, the expectation is that these are completed and returned within one hour. This ambitious target leads to a swift response to immediate risk. However, the pace limits the quality and range of information available to inform initial decision-making about a few children. This is particularly true for situations where needs and risks may not be acute but are complex and chronic. For example, strategy meetings take place very quickly. However, they routinely involve only social care and the police. Information is not consistently good quality. This narrow participation in strategy meetings and limited MACE information means that decisions are

not fully informed by information from professionals and partner agencies. Management capacity within Family Connect has not been enough to deal with the 32% increase in contacts over the last 12 months. As a result, decision-making on 28% of cases is currently taking longer than 24 hours. (Recommendation)

16. Locality assessment teams carry out child protection investigations. These are generally of a good quality. Children are seen quickly. Risk and protective factors are clearly identified. As a result, decisions about further action match children's level of need, whether this be a child protection conference, further assessment, or the provision of child in need or early help services. The emergency duty service is sufficiently staffed by experienced social workers. It provides an appropriate response to concerns that arise out of office hours. There are effective handover arrangements with daytime services.

17. The local authority has focused on improving the quality of assessments. The impact of this was seen in assessments reviewed by inspectors. Almost all assessments completed over the last six months contain chronologies and an account of children's histories. They include relevant information and involve absent fathers and wider family members. While this is positive progress, further improvement is needed for assessments to be good. This is because this information is not routinely analysed effectively or used to consider future risk. The voices of children are recorded, but are not always used to understand their experience or to inform planning. While the response to acute risk is swift and well-coordinated, chronic risk is neither identified nor responded to as quickly. The quality and frequency of the management oversight and direction are inconsistent. This contributes to the delay. For example, in the case of one family seen by inspectors, although the children were subject to a child protection plan, they continued to suffer a pattern of ongoing injuries as a result of neglect. Only after a case audit carried out by the local authority, as part of the inspection process, was this chronic pattern of harm identified and appropriate assertive legal action taken to protect the children. (Recommendation)

18. Good quality specialist parenting assessments, used within court proceedings and other complex family situations, are provided by a dedicated family assessment service. Evidence-based models underpin these assessments. They assess both parenting ability and capacity for change effectively. They provide a model of good practice for the wider service. Most children and family assessments are timely. However, there are delays in completing pre-birth assessments. This is because they begin at 20 weeks gestation, which limits the time to assess. These assessments frequently overlap with, rather than inform, child protection conferences and legal planning meetings. This not only causes delay in some cases, but also means that planning is not always properly informed by the assessment findings.

19. At the time of the inspection, 218 children were subject to a child protection plan. This is an increase from 190 at 31 March 2016. Decisions to make children and young people the subject of child protection plans are appropriate. The rise comes from an improved focus on identifying children who are suffering from chronic harm from problems such as neglect or the impact of domestic abuse. Child protection conferences are well chaired, with good attendance from partner agencies. Conferences use the 'child's lived experience' model. This 'RAG rates' risks, protective factors, and areas requiring further information. The model helps to identify key areas of risk. It helps children, young people and parents to more clearly understand the concerns raised. The '24-hour clock' process is also used to good effect in some conferences. It helps those present better understand children's day-to-day experiences. The increasing use of such evidence-based approaches within conferences is positive. They make conferences more child-centred and effective. However, advocacy is very rarely used to help children and young people be more involved in child protection conferences or other meetings about them. This is a significant omission. (Recommendation)

20. The majority of children are seen regularly and are seen alone. The frequency of visits is increased to reflect the needs of the child when their circumstances merit this. Parents value their relationships with social workers. They say that they feel listened to, have some influence over decisions and are able to access a wide variety of services. However, children's views, although recorded, are not sufficiently influencing plans.

21. The majority of plans, whether early help, child in need or child protection, lack sufficient clarity. Although child protection conferences identify risk effectively, this is not resulting in sharply focused child protection plans. Plans are not always clear about who is expected to do what and by when. This can be confusing for families and professionals and make it difficult to measure progress. The quality of assessments and plans varies, particularly for children in need. As a result, some of them have experienced unnecessary delays in progressing their plans. (Recommendation)

22. A broad range of services and interventions are available to children who are subject to child in need and child protection plans through CAFLS and cohesion services. In addition, the 'Changing Futures' pilot focuses on breaking the cycle of repeat pregnancies and removal of children where there have been previous serious safeguarding concerns. This relatively new and innovative programme is demonstrating its effectiveness, through parents reporting that they feel better able to care for children and in reduced repeat-pregnancy rates. The support provided by the project has also been a key factor in enabling one baby to stay with their mother. Disabled children benefit from personalised good quality, person-centred support plans. The plans are based on a comprehensive assessment of needs and enable them to access a broad range of services.

23. The local authority maintains an up-to-date list of children missing education (CME). There is a named CME officer. At the time of the inspection, there were 21 children missing education and 119 who were educated at home. Staff are tenacious and skilful in tracking CME. They keep a close eye on children's welfare and visit children at home when necessary. They liaise well with other agencies such as other local authorities, schools, professionals and families to share information. They carry out checks to establish the whereabouts of children and whether there have been any previous safeguarding concerns. Managers have good information and intelligence on CME. As a result, the whereabouts of children are known. Also, those without a school place receive good support. They are helped to secure a school place quickly. Staff provide very good support for children and families who choose to educate their children at home. They maintain good contact with the majority of families.

24. There is a strong commitment from the local authority and its partners to tackle child sexual exploitation. A dedicated children abused through exploitation (CATE) team provides good quality risk assessments, planning, and interventions. Although relatively small, the team also reviews progress and updates plans effectively. Consequently, young people receive comprehensive and well-coordinated services that make a positive difference. The team is made up of staff from the local authority, who work closely with a police child sexual exploitation team as a 'virtual' team using a joint service pathway. A tool has been developed to assess risk and protective factors in relation to child sexual exploitation. Inspectors found that the tool was consistently used to both assess risk and inform planning. Recently, sexual health services have been recommissioned to support young people to access support. This is a positive improvement that young people are benefiting from.

25. Extensive awareness-raising has been carried out. This includes presentations from the theatre group 'Loudmouth' to 60 professionals, and the introduction of the 'Something is not right' campaign. This work has not only included relevant childcare professionals and young people themselves, but also taxi drivers, colleges, all local hotels and food outlets. Awareness-raising has now extended to pharmacies. Good joint working with the police and licensing team has had a positive impact. This includes: identifying locations of concern, issuing abduction notices, disclosure in cases of concern, and a number of successful joint operations to disrupt and prosecute offenders. Protection for young people has improved through work with local street pastors and police cadets. They have provided support roles, such as the 'Big sister campaign' and the 'Slipper campaign'.

26. Family Connect reviews all missing children notifications to identify any other concerns in addition to being missing. Return home interview records are screened by the CATE team to identify any specific concerns relating to child sexual exploitation. This is a robust and effective process. However, not all

children receive a timely return home interview to understand their circumstances and any individual 'push or pull' factors. Local authority figures for May 2016 show that just over a quarter of children and young people waited for more than three working days to have an interview. (Recommendation)

27. Risks to children and young people from domestic abuse and high-risk adults are considered effectively in multi-agency risk assessment conferences (MARACs) and multi-agency public protection arrangements (MAPPA) meetings. Single point of contact arrangements are clear. They work well to collate and share information and actions relating to the safety of children. These are then recorded on children and young people's case notes so that they can be considered in other planning meetings, such as child protection conferences or child in need meetings. Inspectors saw evidence of solid multi-agency working to support and protect children who are affected by domestic abuse, parental mental ill health and substance misuse. However, a lack of voluntary perpetrator programmes limits agencies' abilities to tackle and reduce risk.

28. The local authority has strong multi-agency arrangements to protect young people at risk of radicalisation. The 'Channel' panel identifies individuals who are at risk. It assesses the nature and extent of risk. Support plans are developed to divert young people away from extremist behaviour. This area of work is mature, well-coordinated, and integrated into the broader offer of services for children. This ensures that children's wider welfare needs are considered alongside their specific needs arising from radicalisation. Particular examples of good practice in Telford and Wrekin include projects specifically to support parents in understanding extremist behaviour and work with local places of worship to support cross-culture and faith awareness raising. All schools have received 'workshop to raise awareness of Prevent' (WRAP) training. Termly training is held for new staff. However, service pathways are underdeveloped for children at risk of other specific forms of abuse, such as female genital mutilation and honour-based violence. The local authority is aware of this gap. It is currently working with the LSCB to address this.

29. Sixteen- and 17-year-olds who present as homeless are assessed by both housing services and children's services. The local authority is making appropriate decisions about which young people need to become looked after to secure their welfare and which young people can be supported as children in need. Mediation services are provided to help reunify young people with their families, where this is in their best interests. Although the local authority has emergency accommodation, this is not available out of hours. Although only used for relatively short periods of time, this has resulted in the local authority using bed and breakfast for three young people in the last 12 months. Although only used for a very few young people, this is not an acceptable option. The process for securing longer-

term housing is not young-person friendly. A small number of vulnerable young people have been placed in homes of multiple occupation (HMOs) without a good enough assessment of risk.

30. The local authority does not meet its statutory duties for privately fostered children and young people. The local authority cannot assure itself that privately fostered children are appropriately identified because of a lack of awareness-raising activity. The number of notifications has decreased from 34 in 2011–2012 to 13 in 2014–2015. Those children who are currently known to be privately fostered are not seen within statutory timescales. It is not clear where accountability for the line management of this service lies. This has resulted in a failure to monitor the quality and effectiveness of the service. This means that the local authority is not safeguarding these children's welfare effectively. (Recommendation)

31. The designated officer appropriately manages allegations against those in a position of trust. The officer provides advice and guidance to partner agencies. Position of trust meetings coordinate decision making effectively, with robust plans to protect children. Mechanisms to track the progress of individual cases are weak. The local authority is aware of this. Improved arrangements are planned but are not yet in place.

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

Summary

The local authority responds rapidly and effectively to immediate safeguarding concerns. However, when risks are chronic rather than acute, decisions to take children into care are sometimes slow. This means that a few children and young people remain in harmful situations longer than they should. The local authority is aware of this and is working hard to improve practice. Some children still enter care in an emergency, rather than in a planned way, even when concerns are already known.

Assessments are mostly good but are not always used to inform plans for children looked after. Plans are poor. They lack detail, clarity and timescales and, in a very few cases, are not completed. Planning for children looked after is not being driven effectively by review meetings. The IRO service does not provide enough challenge and oversight. The effectiveness of this service is limited by very high caseloads as well as the practice of changing care plans or other important decisions being made outside of reviews without informing the IROs. Children looked after are not always placed under the legal status that best meets their needs. Placements under Section 20 of the Children Act 1989 and placement with parents regulations are not always used appropriately or effectively. The local authority is reviewing their use but this work is not complete. Neither advocacy nor independent visitors are used often enough with those children looked after who could benefit from these services.

Social workers know children looked after well. They are committed to achieving positive outcomes for them. They visit them regularly and use effective direct work to understand their wishes and feelings. Consideration of diversity is also strong. This means that most children looked after benefit from relationships of trust with their social workers. Capable foster carers are providing good care for children looked after. Children say that they feel safe in their placements. The health needs of children looked after are well met and their educational needs increasingly so. Some good targeted support is in place, particularly for Year 11 pupils.

Sufficiency planning has not secured a broad enough range and number of foster carers to meet the needs of children looked after. The local authority recognises this. It is focused on increasing the range and number of placements available. It makes use of independent fostering agencies, particularly for harder to place children and young people to limit the negative impact of this shortfall. Children who could benefit from adoption are identified early, well matched and swiftly placed with adopters who receive good support. However, fostering to adopt is not currently used and this is a gap. Planning is less strong for those who achieve permanence through options other than adoption. This includes those in long-term foster care or who return to their birth families.

Care leavers receive timely support from skilled and experienced social workers and personal advisers. This helps them make successful transitions to adulthood.

Inspection findings

32. The number of children and young people looked after by the local authority has increased, from 293 at 31 March 2015, to 325 at the time of the inspection. Decisions to take children into care are appropriate for their levels of need and risk and are only taken when it is in their best interest. When there are clear and immediate risks to children and young people, the local authority responds rapidly and effectively to secure their safety.

33. When risks are chronic rather than acute, the identification of risk and decisions to take children into care are sometimes slow. This means that a few children and young people remain in harmful situations longer than they should and enter care in an emergency rather than in a planned manner. At the time of the inspection, five of the last 12 children to become looked after had done so as the result of a crisis that had needed the use of police powers of protection or the involvement of the emergency duty service. Some emergency situations are unpredictable. However, in too many cases seen by inspectors, the local authority already knew about the presenting issues that led to the crisis. Earlier action could have been taken if patterns of risk had been identified. The local authority knows that it needs to be better at dealing with such situations. This is reflected in its focus on improving responses to chronic neglect and in the rising number of children coming into care. While this is positive, the practice seen by inspectors shows that further improvement is required.

34. When serious concerns are identified and pre-proceedings work begun, it is usually done well. Thresholds for action are set at the right level. Assessments completed for the courts are mostly good and are getting better. The local authority has worked hard to improve the quality of court assessments, statements and reports. These documents are scrutinised by both team and senior managers before being passed to legal services for further review and filing with the court. This improvement has been noted by both Cafcass and the judiciary. Despite earlier delay in identifying patterns of risk and in progressing some children's cases to this point, most pre-proceedings work and court proceedings are progressed without significant delay. Legal planning meetings are used effectively to set the pace of work, to maintain oversight and to manage the progress of cases through the court. In most cases, potential carers are identified early for those children who cannot return to, or remain in, the care of their immediate families. However, this is not the case for all children. For a very few children, the local authority has still been looking for suitable carers at the point of the final hearing. When the plan is to place children with connected person carers, there have been frequent delays. These are caused by a lack of capacity to assess this type of carer. The local authority has recognised this shortcoming. It has recently added extra staff to the relevant team, although this is yet to have a significant impact.

35. When children or young people are accommodated voluntarily under section 20 of the Children Act 1989, this is often not well organised. Voluntary arrangements are not always appropriate to children's circumstances. Parents spoken with by inspectors were not always given enough information to make informed decisions. The agreement they were entering into was not explained clearly enough to them. This included parents who speak English as an additional language and situations where children were placed within the extended family. In such situations, this has led to confused decision making and unclear contact arrangements for children. For a few of these children, it has also led to delays in them securing a permanent home, either in care, or back with their families. The local authority is reviewing the appropriateness of planning for all those children placed under section 20. However, this work is not yet complete.

36. The local authority does very well at identifying children who could benefit from adoption early and swiftly matching them with adoptive carers. However, it does not move children into other permanent placement options so quickly. Plans for permanence are not routinely discussed at second reviews of children looked after and care planning meetings are not consistently taking place. Progress is very much dependent on the individual social worker. It has not been given any systemic urgency, either through the role of the IRO service or performance management arrangements. The local authority recognises this delay in securing permanence for children. It has created a permanence panel to improve decision-making, oversight and monitoring for all permanence planning from July 2016 onwards. It also plans to use this new process as part of its ongoing review of the situations of those children and young people looked after under section 20.

37. When children and young people return to the care of their families, this is not well managed. In all 10 of the children's cases selected for review by inspectors, none of them returned home as part of a planned move. Reunification processes lack both clarity about continuing risk and effective planning. This is true for those who have only spent very short periods of time in care and for those returning home after a longer period in care, who are subject to care orders and placement with parents regulations. For this latter group, regulations are neither being fully adhered to nor used effectively. Decision-making about these children is vague. Plans do not always reflect the ultimate aim, for example whether a care order should be revoked and when. Inspectors saw no case of a child or young person suffering significant harm as a result of this. However, children were placed in situations where risk was not fully understood and support insufficient to ensure a successful reunification in all cases. The new permanence panel will monitor this group of children from July 2016, with the aim of ensuring a tighter grip on planning. While this awareness on the part of the local authority is positive, the panel is yet to start its work. So, it has not had an impact on improving practice with, or outcomes for, this group of children and young people.

38. Sufficiency planning has not secured a broad enough range and number of foster carers to meet the needs of children looked after. For example, although the local authority appropriately assesses whether brothers and sisters should live together or apart, when larger sibling groups become looked after, and it is in their best interests to be placed together, some of these children have been placed with different foster carers due to a lack of suitable placements. The local authority recognises this gap in placement sufficiency. It has focused efforts on increasing the range and number of placements available. It is working particularly hard to recruit carers who can meet the needs of large brother and sister groups, older children, disabled children and those from minority ethnic backgrounds. The local authority has committed extra, 'invest-to-save' money to help with recruitment and to improve support to foster carers, including out of hours. It is making up for its shortage of suitable placements by using independent fostering agencies. This limits the negative impact on children and young people.

39. Despite these concerns, the vast majority of children in the care of the local authority live in good quality placements. Committed carers provide a high standard of care and support to meet their individual needs. Foster carers provide stable short- and long-term placements. They also act as advocates for children and young people placed with them and communicate well with social workers. Children and young people told inspectors that they feel safe in their placements. Contact between children looked after and their family and friends is appropriately considered and promoted by the local authority. However, a lack of capacity within the contact team means that on a few occasions, contact is cancelled at short notice. This can be confusing and upsetting for children and young people. (Recommendation)

40. Foster carers receive regular visits from their support workers and a broad range of relevant training. A large majority of foster carers spoken to by inspectors said that the training they receive is helpful and high quality. Foster carers are more mixed in their views about how helpful their support workers are. While they all receive regular visits, some said that support for managing difficult situations is not readily available out of normal office hours. As a result, they had had to contact the emergency duty service or police as the only support option readily available at these times.

41. Social workers in Telford and Wrekin know the children and young people they are working with well. They are committed to ensuring positive outcomes for them. They visit children regularly and see them on their own. They also use a variety of tools and imaginative approaches to help draw out and understand their wishes and feelings. This means that most children looked after benefit from relationships of trust with their social workers. Inspectors saw evidence of social workers using this understanding to identify the right support for children looked after. This was not always reflected in written plans. Multi-agency meetings, such as looked after

reviews, personal education plan (PEP) meetings and placement stability meetings are well attended by partner agencies. Partner agencies also contribute well to assessments of children looked after. The exception to this is the child and adolescent mental health service (CAMHS), which is less well engaged. The local authority is aware of this gap in service provision. It is working closely with health partners to commission a new birth to 25 emotional health and well-being service. This is due to start in 2017. Currently, the local authority directly commissions and procures a range of therapeutic and emotional well-being services to meet the individual needs of children looked after. This is good practice.

42. Most assessments of children looked after are good. They are generally better than those completed earlier in the local authority's involvement with children and their families. They contain detailed information about children and their families, including children's histories. They clearly identify risk and protective factors. Analysis is stronger. The local authority has focused on ensuring that children looked after are re-assessed when their circumstances and needs change. This practice is now routine. However, inspectors found that assessments rarely inform planning. Often, assessments follow on from, rather than inform, significant decisions or events in children's lives, such as placement moves or decisions about contact.

43. Although not always reflected in plans or written assessments, social workers' casework with children looked after shows good consideration of their needs arising from such factors as ethnicity, culture, gender, sexual orientation and disability. This understanding helps children to build trusting relationships with social workers. It is influencing the support provided to them. Inspectors saw some strong work with children looked after, including disabled children and young people, to help them understand the complexity of their family histories and its impact on their identity. Social workers involve other professionals and agencies in this work when it will benefit children looked after.

44. Written plans for children looked after are poor. They lack detail, clarity and timescales. They are not always informed by assessments and, in a very few cases, are not completed. This lack of detail and clarity is also present in the majority of records of the review meetings for children looked after. These meetings do not always take place within agreed timescales. Review meetings directly observed by inspectors were well chaired and the IRO's challenge and oversight of planning were evident. However, this challenge and oversight is not clearly shown in records of review meetings and there is little evidence of its impact in children's plans and care histories. Records of meetings are often produced late and show little evidence of challenge by IROs or of how the review is informing planning. Care plans and decisions are sometimes changed outside of review meetings and without informing IROs. As a result, children and young people have returned home, moved placements or had plans submitted to the courts without enough oversight

by IROs. IROs have caseloads substantially above statutory guidance. This significantly limits their ability to keep in touch with children looked after between reviews and to track the progress they are making. (Recommendation)

45. Although inspectors saw some good individual examples of the effective use of advocacy to support children and young people and engage them in shaping the services that they receive, this service is not routinely considered or used for children looked after. Many children looked after who could benefit from advocacy are not being offered the service. Children looked after had the support of an advocate in just 33 reviews between June 2015 and June 2016. Similarly, not all children looked after who could benefit from an independent visitor have one and those that have said that they would like one are experiencing delay in being matched with a visitor. (Recommendation)

46. The majority of children looked after are receiving support that helps them achieve good school attendance and make progress in their education. The virtual school team maintains good oversight of the progress of children looked after. It closely monitors those most at risk of not achieving. Effective work by the virtual head teacher and managers from children's social care has much improved the stability of education placements. When a child or young person has to move placement, managers liaise effectively to decide whether a change of school is in their best interest. As a result, fewer children looked after experience disruptions to their schooling. An increased proportion of children looked after attended a school judged good or better during the last academic year. When a school is judged less than good following inspection, managers carry out thorough risk assessments to decide whether a change of school is the best thing for individual children looked after.

47. The attainment of children looked after in Telford and Wrekin is broadly in line with children looked after nationally. However, the gap between the attainment of children looked after and their peers remains wide. Managers have provided targeted support this year to improve outcomes for children looked after and to close the attainment gap. For example, all those in Year 11 have received extra one-to-one support in English and mathematics. Young children have received one-to-one support to improve their reading skills.

48. An increasing proportion of children looked after have an up-to-date PEP. However, the quality of PEPs is too variable, with most requiring improvement to be good. PEP targets are not always specific enough about what children need to do to make progress and achieve well. Children's views are not always well recorded. Inspectors saw good use of the pupil premium to support children's progress, but generally, the use of the pupil premium was not specified clearly enough in PEPs. (Recommendation)

49. Children looked after who attend alternative provision and those who are on modified timetables receive good support. Bespoke programmes meet the individual needs and circumstances of children well. As a result, they improve their engagement and attendance at school and make progress. Very few children looked after go missing from school. At the time of the inspection, there were no children looked after without a school place. However, support for education for children and young people placed out of the area is inconsistent. In a minority of cases, the virtual school does not have enough information on those placed out of the area to enable them to plan and provide timely support.

50. The health needs of children looked after are well addressed. The vast majority of health assessments are completed within statutory timescales. Support provided to meet the health needs of children looked after is good and improving. This is largely due to good support offered by health visitors and specialist school nurses. For children looked after who are placed further away, health reports are less detailed or timely. However, when any concerns arise, these children looked after are supported well by the designated doctor and children looked after nurse.

51. Social workers and carers support children looked after to pursue a range of leisure activities. They ensure that children routinely have access to extra-curricular activities. Children and young people are also provided, through the work of the corporate parenting board, with opportunities for learning and development and to celebrate their successes.

52. The Children in Care Council, 'Voice', is effective. It engages well with, and listens to, children looked after. It also provides a positive venue for a broad range and age of children looked after to meet, socialise and exchange views. 'Voice' skilfully supports children looked after to give their views, take part in consultations and provide feedback on important issues. The lead member and DCS are regular attendees. They are well known to 'Voice' members, who say that they feel listened to by them.

53. The corporate parenting board is proud of the Children in Care pledge and the work completed to ensure that its redesign has captured the views of children and young people. The pledge contains an ambitious and highly relevant list of promises, touching on all areas of life for children looked after. It is a strong document. The local authority has worked hard to publicise the pledge. However, there is no monitoring or other system in place to see what difference the pledge has made in improving the lives of children looked after. Children looked after spoken to by inspectors were mostly aware of the pledge. However, none were familiar with the offer it contains or had considered using the pledge as a mechanism to access support or challenge any aspects of their support that they were unhappy about.

The graded judgement for adoption performance is that it is good

54. Adoption is considered for all children who are unable to return home and who may benefit from it. This includes older and harder-to-place children, such as those with brothers or sisters. Those children for whom adoption is the best route to permanence are identified at an early stage in care planning. There is appropriate urgency in care planning and decision-making to ensure that adoption plans are timely.

55. The managers of Telford and Wrekin and Shropshire joint adoption service have a clear understanding of effective adoption practice. Monthly management board meetings are used to analyse the adoption service's performance robustly. They focus on any problems or issues affecting the timeliness and quality of the work. Managers have a detailed knowledge both of children and adopters.

56. The progress of children requiring adoption is tracked effectively through the monthly referral and tracking meetings that monitor the progress of decisions through to care proceedings. This avoids unnecessary delay and ensures that placement options are continually monitored. The initial alert, through the referral process, ensures that the adoption team is fully informed of children who may benefit from adoption at an early stage. This ensures that the adoption team has the opportunity to consider not only those adopters already approved but also those being assessed, at a very early stage in the matching process.

57. The number of children in Telford and Wrekin benefiting from adoption increased from 20 in 2013–14 to 35 in 2014–15. Although numbers decreased to 15 in 2015–16, at the time of the inspection, three months into the year 2016–17, 20 children were identified for adoption. Of these, 14 children have either already progressed to an adoption order or are matched to adoptive families with planned dates for moving in with their adoptive families. Family finding is underway for the other six. This includes the assessment of three sets of existing foster carers who have expressed a wish to be the adoptive families for the children.

58. The most recently published adoption scorecard for 2012–15 shows that Telford and Wrekin has the best performance in England for timeliness against the scorecard indicators. For children being adopted, the average time between entering care and moving in with an adoptive family was 336 days. This is 151 days within the government threshold of 487 days. The time between receiving court authority to place a child and deciding on a match with an adoptive family is very quick, at 47 days. This is 74 days within the 121 day threshold. Eighty-five per cent of children waited less than 16 months to move in with their adoptive families. This is much better than national average of 47%. Although timeliness for seven children was

outside the threshold, there are good reasons why adoption took longer to achieve for these particular children. This strong adoption performance shows urgency and effective focus on making sure that children do not experience unnecessary delays in being placed with the right adoptive families.

59. Focused and effective family finding is carried out by a dedicated permanence coordinator. She is tenacious and proactive in pursuing choices and links for children through a variety of networks. The matching of children with Telford and Wrekin approved adopters is the first choice. It is achieved for almost all children. When this does not happen, it is usually for 'harder to place' children who are part of large sibling groups, older or have complex needs. In such cases, prompt referrals are made to the National Adoption Register, other links such as Adoption Focus and the local West Midlands adoption consortium. In 2014–15, successful matches included three sibling groups, made up of eight children. In 2015–16, this figure increased to 10 children, consisting of five sibling groups. In the current cohort of 20 children, two groups of brothers and sisters have been successfully matched, including a group of three.

60. Adoption performance for older children, those with complex needs and children from black and minority ethnic backgrounds is not as strong as for young children. The authority is very much aware of this. It is improving practice and performance in this area. The current cohort contains two children of mixed parentage, three over-fives and three with complex health needs.

61. There have been no pre-order adoption disruptions in the last two years and numbers of revocations are very low. This shows the commitment and effectiveness of family finding and of good matching and information sharing. Children are well prepared for their adoptive placements, with foster carers playing a key role. A dedicated, experienced social worker within the team undertakes pre-adoption work with children. 'Theraplay' work is being used effectively to prepare children for the transition to adoption. It is also being used well to help re-establish relationships between brothers and sisters and to increase their understanding of adoption and their place in their adoptive families. Good quality, child-focused, therapeutic life story work is used to sensitively understand and recount children's histories and their ongoing experiences.

62. There is a coherent recruitment strategy for adopters. It is based on predicted numbers, needs and profiles of children. The joint adoption service is working with an external agency on recruitment and marketing. This is to broaden both the range of potential adopters and awareness and interest in adoption. Prospective adopters are well informed through information sessions, which have been increased to two per month. Twenty-seven

adopters were approved in 2015–16. At the time of the inspection, seven adopters were at stage one of the process and 13 at stage two.

63. Adopters spoken to describe the recruitment, preparation and assessment process as thorough. They said it was stressful, sometimes intrusive and challenging but brought 'great rewards'. The recruitment process is strong, timely and child-centred. Pre-adoption reports include good exploration of the prospective adopters' strengths, reasons and commitment to adopt. While analysis is clear and supports recommendations, it is not always clear how social workers have used research when analysing the impact of the prospective adopters' living experiences. A few delays in progressing assessments were noted but these were for good reasons and not due to a lack of urgency by the service. The impact of delays has been minimal on both children and adopters.

64. The adoption panel is effective, providing rigour, scrutiny and challenge. The panel thoroughly considers recommendations for approvals, the quality of matching and fully explores the potential adopters' motivation to adopt. For example, in one case, panel members explored the adopters' understanding of identity and ethnicity. It considered the impact on non-white children of being placed with white carers in a predominantly white area and recommended further work with the adopters using research about identity. The agency decision maker makes timely decisions and, where necessary, requests further information to inform decisions. The panel chair is provided with information and kept up to date about children and adopters. However, there is no formal or agreed meeting framework between the adoption chair, the manager and the decision maker. This has the potential to delay the sharing of information and intelligence, and so slow the functioning of the adoption service.

65. Foster to adopt is at the early stage of development within the joint adoption service. There are two families going through the assessment process but no fostering to adopt placements have been made. This is a missed opportunity to provide continuity of care and promote early attachment for some young children with their prospective adopters.

66. The post-adoption service is strong. It is enhanced by having three therapists located within the team. They offer a range of therapeutic interventions and support to children and their adoptive families, including coaching and mentoring. They also work directly with children and their adoptive families to assist 'attachment repair'. This has been successful in developing relationships. The joint adoption service makes good use of the adoption support fund to commission specialist, psychotherapy and psychological support. In 2015–16, 14 children and 12 adoptive families received post-adoption support.

67. Adopters say that they receive good support from the joint adoption service. Some described the support as 'excellent' and added that they also got good quality post-adoption information. One adopter said 'I do not know what would have happened had we not received the support'. Some adopters said that they thought that post-adoption support should be further strengthened by targeting support at the period immediately after the order is made. Independent advice, support and counselling for birth parents and relatives is commissioned through a voluntary adoption agency. In 2014–15, 17 birth parents and relatives received support, including training. Ten birth parents accessed counselling services in 2014–15 and 10 in 2015–16. Three hundred and eighty-eight letterbox arrangements are in place. Both adoptive and birth families are supported to maintain these arrangements.

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

68. There is a well-considered system for allocating social workers and personal advisers to young people leaving care. Young people who are settled and doing well receive effective support from personal advisers. Young people with more complex needs receive help and support from allocated social workers. Personal advisers give them extra practical help.

69. Social workers and personal advisers maintain good contact with young people, including those who live outside the local authority area. They regularly see young people face-to-face and keep in touch by phone, email and text. This ensures that staff are alert to young people's circumstances and current needs.

70. Young people spoken to by inspectors value highly the practical support that personal advisers provide. This includes attending medical appointments with them, supporting them to budget more effectively and helping them access benefits.

71. Social workers and personal advisers have good oversight of young people's needs. They plan effectively to meet these. Nearly all young people have an up-to-date pathway plan and are well involved in developing their own plans for the future. Staff are aware of young people's anxieties and their changing needs. They are quick to adapt plans when young people's circumstances change.

72. Many care leavers achieve good outcomes. Those with more complex needs are well supported to take small steps in their transition to adulthood. This includes improving attendance at medical appointments and at therapy sessions. Social workers are persistent in their support for young people and stick with them through their ups and downs. They liaise well with other

agencies such as the family nurse partnership, probation and the police to ensure that the level of support that young people receive meets their needs and that they are safe.

73. Staff maintain good oversight of those care leavers who spend time in custody. They keep in touch with them regularly and plan effectively for their release, for example in maintaining young people's tenancies so that they have safe, secure and familiar accommodation on their release.

74. The small number of care leavers who are unaccompanied asylum seekers receive effective help. They are placed quickly in specialist accommodation with other young people from similar backgrounds and quickly settle into further education.

75. Well-coordinated work by personal advisers, social workers and advisers from 'Future Focus' with those who are not in education, training or employment is increasingly effective. Staff meet regularly to review those care leavers who are not making good progress. They plan new actions to help them secure a place in college or employment. As a result, the proportion of care leavers who secure an education, employment or training place is improving significantly.

76. There is a good range of courses and programmes that help care leavers to build their ability to seek and maintain education, employment and training places and to develop their skills, including for independent living. Alongside the initiative of individual social workers and personal advisers, this helps young people raise their aspirations and successfully take their next steps into adulthood. For example, one social worker visited art galleries with a young person. This further developed their interests and raised their aspirations. The summer arts programme also helps to motivate young people. It supports their personal and social development and helps them to achieve qualifications.

77. The 'Care Leavers First' group provides young people with good opportunities to meet regularly, develop friendships and have a say in matters that affect them. They have opportunities to learn about their rights and entitlements, such as housing. It helps them get extra support and guidance from staff.

78. There is effective and proactive planning for disabled young people. This ensures that young people's needs are known and that appropriate plans are made for their timely transition to adult services. As a result, young people live in suitable accommodation and pursue their next steps in education, employment or training successfully.

79. The financial support available to care leavers is good. The finance policy details what is available to young people. It includes their personal and

birthday allowances and the £2,000 grant available to set up their first home. There are good financial incentives available for employers to take on care leavers as apprentices and discretionary payments for care leavers to top up the apprenticeship wage. Despite this, a relatively small number of care leavers complete an apprenticeship programme. Similarly, the number of those attending university is low.

80. Young people are aware of the medical services available to them. Most are registered with a GP and dentist. A health passport has been introduced. Although not all young people are aware of it, most spoken to by inspectors said that they knew about their health history and how to access health services. Young people are supported effectively to gain important documents such as their birth or adoption certificates, driving licence, passport and national insurance number.

81. Most young people live in suitable accommodation that is safe and meets their needs well. Care leavers spoken to by inspectors felt safe where they lived. However, the range of accommodation available to young people is too narrow. For a small number of young people placed in HMOs, the local authority does not know what risks other residents living there may pose. Inspectors identified a small minority of cases where living in HMOs hindered young people's progress towards good outcomes. Bed and breakfast accommodation, while only used in exceptional circumstances, has been used for one young person over the last year. Too few care leavers, including those with more complex needs, benefit from arrangements to support them to remain with their foster carers beyond their 18th birthday. (Recommendation)

Leadership, management and governance	Requires improvement

Summary

The director of children's services and his senior team provide strong leadership, both within the local authority and across the partnership of agencies. They have made important improvements to the quality of services and to the outcomes that children achieve. The relatively recent appointments of the DCS and the assistant director for safeguarding, in January 2016 and September 2015 respectively, have been a particular catalyst for accelerating ongoing improvement work. This progress has been helped by effective political backing and the hands-on support of the managing director. However, services received by children in Telford and Wrekin are not yet consistently good. This is because some developments are too new to have made a significant difference, others are not yet in place and gaps remain in the quality of first-line management oversight and scrutiny.

The local authority has championed work to tackle child sexual exploitation and provided leadership to partner agencies. It has worked well with the local safeguarding children board and other agencies to put in place a clear and effective strategic framework for this work. The development of the Family Connect service into a MASH has created an effective front door to services. Early help services are working increasingly well to prevent children needing statutory intervention.

As a corporate parent, the local authority is improving the health and education outcomes of children looked after, increasing placement stability and providing a good service for care leavers and children who could benefit from adoption. However, it has not managed to recruit a sufficient number and range of foster carers to provide suitable placements for all the children and young people who need them. Housing options for care leavers and homeless young people are not consistently meeting need.

Performance management and quality assurance systems provide a largely accurate picture of performance but are not being used fully effectively to drive up standards. This is because measures being monitored are not always updated to reflect changing or new priorities and this work is not informed by feedback from children and their families. The IRO service is not providing enough scrutiny and drive to planning for children and young people and does not have a clear overview of service performance. The effectiveness of this service is reduced by caseloads significantly above statutory guidance.

The local authority has worked hard to ensure that almost all social workers have manageable caseloads. It has increased workforce stability and reduced reliance on temporary agency staff. The majority of social workers receive regular supervision and management oversight of their work. However, gaps in the supervision and case direction received by a minority of social workers is leading to delays in progressing work to improve outcomes for some children.

Inspection findings

82. The local authority improvement plan for children's services in 2015–16 has not yet been fully implemented and inconsistencies remain in the quality of support offered to children and young people. The DCS and senior leaders are focused and energetic. They largely know what improvements need to be made and understand what is happening on the front line. There are many plans in place to support these improvements across the entire service. However, at the time of the inspection, these improvements had not been sufficiently realised to ensure consistently good services for children and young people. In particular, gaps remain in the quality of first-line management oversight and scrutiny and the work of the IRO service.

83. The local authority has focused on ensuring that the initial response to children is effective. Family Connect is providing a timely and appropriate response to children when their needs are first identified. The children abused through exploitation team (CATE) is delivering high-quality services to children who are at risk of, or have been subject to, children sexual exploitation. Improvements such as these are making a positive difference for children.

84. At a senior level, the managing director has taken an active role in monitoring the work of children's services, including undertaking monthly audits of children's case files. He has instigated effective action to address problems identified. In addition to regular meetings with the DCS, he meets every two months with the director, the assistant director responsible for safeguarding, the lead member for children and the independent chair of the local safeguarding children's board. As a result of these meetings, there is a cohesive approach to improvement and a financial commitment to protect frontline services. The managing director and lead member are very clear that there is a 'whole-council' commitment to ensuring that children and young people are effectively safeguarded. This proactive approach has resulted in a number of innovative projects. For example, the successful 'changing futures' programme aims to break the cycle of repeat removals of children from their birth parents.

85. The corporate parenting board has been effective in directing and driving change. For example, improving the completion of the strengths and difficulties questionnaire for children looked after has resulted in an increased understanding of their emotional health and well-being needs. A sports and leisure scheme, which encourages children and young people to use facilities for a free period, has also been introduced. The corporate parenting board is regularly attended by the lead member and representatives from children's services. However, some key partners only engage occasionally. This is resulting in opportunities to address wider issues

being neglected. For example, care leavers are not yet provided with priority housing.

86. The joint strategic needs assessment (JSNA) focuses on the safeguarding and social care needs of children within three 'locality profile' documents. These documents contain a range of helpful information. However, there are gaps, particularly in relation to the 'toxic trio' of domestic abuse, parental drug, alcohol and substance abuse and parental mental ill-health. For example, no information is included about the number of adults receiving mental health or drug, alcohol or substance abuse services who are parents or have caring responsibilities. This limits the information available to agencies working together within the health and well-being board (H&WB) and early help partnership (EHP) to understand need, set priorities and commission services to address them.

87. Agencies are working well together within the H&WB and EHP. Although there is no shared multi-agency plan or set of agreed priorities for children's social care needs, against which services can be commissioned or progress measured, this is balanced by close working, a shared commitment to improve and a common understanding of the most important areas for improvement. This has driven the commissioning of a new birth to 25 emotional health and well-being service, to start in 2017. The EHP has recently scrutinised the draft service specification for the planned service. It ensured that it was altered to have a stronger and clearer focus on the needs of the most vulnerable children and young people.

88. The local authority's process for commissioning services is effective. This is because children's services managers and commissioners work closely together. They link commissioning and professional expertise. As a result, service specifications deliver services that are fit for purpose and address identified need. Parenting assessments and the 'changing futures' project are good examples of such well-focused services. This process is strong and underpinned by a clear local authority commissioning and sufficiency strategy. However, the lack of a shared multi-agency strategy or plan makes it more difficult to address gaps in service provision, such as the lack of a domestic abuse perpetrators programme.

89. Recent significant reductions in the length of care proceedings mean that more children in Telford and Wrekin who need a permanent home are getting this in a timely manner. However, there are still children who have not benefited from timely permanence planning. Despite being looked after for several years, some children are still not living in permanent homes. The local authority's fostering recruitment strategy is not meeting its target to ensure that it has enough carers with the right skills to meet the needs of children looked after, particularly those who are older or who have brothers and sisters who also need to be looked after. The local authority is not supporting enough children looked after to remain with their carers beyond

18. There are currently just six young people in staying-put arrangements. (Recommendation)

90. The IRO service, which is responsible both for child protection case conferences and children looked after reviews, is not fully effective in providing scrutiny and drive to planning for children. IROs are not routinely tracking the progress of children's plans between reviews or challenging areas of poor practice, such as agencies other than the local authority not providing written reports in advance of child protection conferences. The ability of the service to operate effectively has been, and continues to be, held back by several factors. The main cause is caseloads that are significantly in excess of written guidance, while staff sickness vacancies and inconsistent management of the service also play a part. (Recommendation)

91. Targeted work by the local authority has led to improved communication and joint working between children's services and schools in Telford and Wrekin. Schools are positive about the advice and support they receive in several areas. They appreciate the positive difference it has made. This includes work on children missing education and tackling child sexual exploitation and radicalisation. This positive relationship has led to schools being more ready to take on the role of lead professional in CAFs. Schools contribute well to CAFs. This is strengthening the early help offer to children. The virtual school is working well with schools. There is good information sharing and strong oversight of children looked after. As a result, the educational achievement of children looked after is starting to improve.

92. The local authority has made good progress in its work to combat child sexual exploitation. It has worked well with the TWSCB and partner agencies. Together, they have put in place a clear and effective strategic framework to tackle child sexual exploitation. Through this and other actions, the local authority has championed work in relation to this issue and provided leadership to the partnership. An 18-month overview and scrutiny committee review of the partnership response to child sexual exploitation has recently been completed. This shows the strong commitment to tackling this issue. The review has been valuable in developing a detailed understanding of the scale of the problem. It studied the range and effectiveness of services in place and what can be further improved. However, an unfortunate consequence of this rigorous focus on child sexual exploitation is that the committee has given little consideration to any other welfare and safeguarding needs of children.

93. The local authority has ensured that children who go missing are offered and receive return home interviews. However, it is not ensuring that these interviews are all carried out in a timely manner, nor has it made best use of intelligence from return home interviews to identify themes that could help improve services. The content of interviews has only very recently started to be collated and analysed to identify such themes. The identification of the

'pull' factors that lead young people to go missing has been a particular gap in the analysis of this information when it is considered alongside information about those who may be at risk of child sexual exploitation. (Recommendation)

94. The use of performance management and quality assurance processes to assess the impact and improve the quality of services for children requires further strengthening. While there is a strong focus on performance, the development of a performance culture is still work in progress across all areas of the service. For example, senior managers do not have a direct line of sight to some key aspects of frontline practice, such as the frequency and quality of supervision, and team managers are not consistently using performance information to support them in understanding their priorities. There is no standard mechanism to collate information on the views of children who have received services. There are some good individual examples of children being listened to, and consultation with children looked after and care leavers, through the 'Voice' and 'Care Leavers First' groups, is good. However, the lack of a formal mechanism for gathering feedback limits the local authority's ability to understand the quality of services. For example, the views of children who have made complaints, received advocacy services or had return home interviews are not aggregated to identify themes or set alongside performance data or information from audits to help develop a more rounded understanding of the quality and impact of services. Although inspectors saw positive outcomes being achieved for children, the local authority is not sufficiently evaluating the impact of early help provision. This limits its understanding of what is effective and why. This is a priority for the local authority and a pilot scheme is currently under development with the support of the TWSCB. (Recommendation)

95. Audits are increasingly well used to improve performance and most case audits are of good quality. During the last 12 months, a stronger emphasis has been placed on understanding and acting on messages from audits. This has resulted in changes such as improvements in the frequency of statutory visits and the completion of chronologies. However, while this is positive, the local authority audit tool does not provide a clear narrative of what 'good' looks like for individual judgements and follow-up audits are not routinely completed to check the impact of improvement actions. Building on previous improvements in the use of quality assurance information, a new quality assurance plan contains within it, a quality assurance framework and a quality assurance activity timeline covering all services within the year 2016-17. This is a strong document and a positive step but, as yet, the impact of this new way of working cannot be seen in practice.

96. The majority of social workers receive regular supervision and management oversight. When this is supported by the reflective 'pods' approach, the quality of case discussion is generally good and has a sharp focus on the wishes and feelings of children. However, gaps remain in the quality and

frequency of the supervision, case direction and oversight received by some social workers. Where such gaps exist, they lead to delays in progressing work and improving outcomes for some children. The quality and consistency of work with children and their families is a priority for the local authority, and in particular the quality of social work assessments and plans and the timeliness of responses to chronic neglect. This inconsistency in management oversight, combined with the limited effectiveness of the IRO service, is a significant factor preventing the local authority from achieving its aim of providing a consistently good service. (Recommendation)

97. A strong training and development package, alongside targeted advertising and specific funding for additional staffing, has enabled the local authority to reduce staff turnover. For this reason, there is an increased percentage of staff who are full-time and the borough has reduced its reliance on agency social workers. More staff means that most social workers in Telford and Wrekin have manageable caseloads. This means that social workers are more likely to be able to see children often enough to build relationships of trust with them. It has also supported the recruitment and retention of social workers.

98. Newly qualified social workers who are in their assessed first year of employment (ASYE) say that the quality of the training and support they receive is helping many of them decide to remain in Telford and Wrekin. All social workers spoken to by inspectors were positive about working for the authority. This was particularly the case for new staff who benefit from a structured three-week induction. Social workers speak highly of the support that they receive and of a very visible management team. The workforce strategy has recently been reviewed. It is now a whole-council strategy, which supports the local authority's 'being the change' principles. This new strategy focuses on core behaviours and culture. However, it is too new to have had a significant impact. The principal social worker is influencing the direction of this strategy by ensuring that the children's workforce is supported through career progression and training. The service has just completed its annual health check of social workers. While the initial messages from this are positive, it has not yet been published. The assistant director offers opportunities for staff to talk with her about practice through a communications group. This provides a mechanism for leaders to understand what is happening on the front line. The open discussion within meetings is well received by staff.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is good

Executive summary

The Telford and Wrekin safeguarding children board (TWSCB) is strong. Partner agencies work together effectively within the board. It has a strong independent chair who provides clear direction and effective challenge. Governance is strong. The independent chair also chairs the adult safeguarding board. This helps improve the join-up between services for adults and those for children. Effective links with the health and well-being board (H&WB) and early help partnership (EHP) help ensure that children are a priority across the key strategic partnerships. The board does not work with the family justice board (FJB). Plans are in place to address this gap.

The board plays a key role in driving and shaping developments such as the establishment of the MASH and implementation of 'Operation Encompass'. Partnership working to tackle child sexual exploitation is strong. The board is also driving the implementation of the Neglect and Children Harming Children strategies. The TWSCB annual report 2014–15 gives a comprehensive account of the board's activity, its achievements and priorities but lacks a similarly comprehensive analysis of the quality of services to safeguard children.

The board receives good quality performance information. However, the range of information is not broad enough to produce a fully integrated multi-agency data set. The board continues to work on this as a priority. The board receives information about children at risk of sexual exploitation and from going missing. It has recognised that it could also helpfully focus on other vulnerable groups, in particular children looked after. A robust multi-agency auditing programme is in place. The board also receives reports on the findings of single-agency audits, including those relating to early help. In addition to an effective peer-review process, the safeguarding questions asked in the Section 11 audit are regularly reviewed by the board.

The board evaluates the application of thresholds through regular audits. Its threshold document, 'The child's journey', provides helpful guidance but does not fully reflect current statutory guidance. Similarly, the generally comprehensive and accessible policies available via the TWSCB website include guidance but not clear service pathways for children and young people at risk of female genital mutilation, honour-based violence or forced marriage. A good range of training is provided by the board, and this is clearly shaped by the board's priorities.

The TSCB does well at engaging with and listening to children and young people. Its 'Team safeguarding voice' initiative has very successfully involved children in raising awareness about safeguarding issues. It is now in place in 30 schools.

Recommendations

99. Revise the Child's Journey threshold document to fully reflect current statutory guidance and to provide greater clarity about the distinction between children in need and those with additional needs and the thresholds for accommodation and court action.

100. Update the TWSCB procedures to include clear service pathways for children and young people at risk of female genital mutilation, forced marriage and honour-based violence.

101. Sharpen the board's focus on children looked after, particularly those living outside the local authority boundary and those involved in offending behaviour.

102. Establish links to, and work with, the local Family Justice Board.

103. Strengthen the analysis of the quality and impact of safeguarding services within the annual report 2015–16.

Inspection findings – the Local Safeguarding Children Board

104. The TWSCB is well organised and effective. It has a clear structure that promotes the delivery both of its core business and its priorities. Membership is appropriate and includes three lay members. The lead member for children's services attends each meeting as an observer. Attendance is good. Partnership working is a strength and is characterised by trust and challenge. The board provides focused and effective challenge and leadership to agencies. This has resulted in a number of improvements. These include the roll out of 'Operation Encompass', which supports better information sharing about domestic abuse. This work has helped to shape the restructuring of early help services. A challenge log has recently been set up. This helps the board to ensure that challenge to agencies is followed up until necessary change is achieved.

105. All board members spoken to by inspectors expressed their confidence in the chair. He has a clear focus on improving outcomes for children. He has worked hard to ensure that this is reflected in the board's activity and that the board operates efficiently and effectively. He has regular meetings with individual board members, which enables each one to make a full contribution. He also meets with sub-group chairs on a quarterly basis.

106. Governance works well across the strategic partnerships. The chair meets regularly with the DCS and the managing director to help ensure these links. The chair attends the H&WB board on an annual basis to present the TWSCB annual report. He meets with key stakeholder groups, such as the clinical commissioning group, IROs and GPs. The board's business manager attends

the H&WB strategy delivery group and, after a challenge by the TWSCB, the health and well-being strategy has been revised to improve its focus on safeguarding children. The chair also chairs the adult safeguarding board. There are plans for the domestic abuse thematic sub-group to report on progress to both. This will ensure that improvement activity is aligned. There is an acknowledged gap in relation to links with the FJB. (Recommendation)

107. The TWSCB annual report 2014–15 provides a comprehensive account of the board's roles and responsibilities, and its activity and achievements. It sets out the priorities for the coming year. However, analysis of the quality and impact of services to safeguard children and young people is not as rigorous as it should be, given the monitoring and scrutiny work that the board carries out. The report does not clearly reflect improvements in agencies, services and practice that have resulted from challenge by the board. (Recommendation)

108. The board has an agreed data set that includes statutory as well as local indicators developed to reflect its priorities. The quality performance and operations sub-group routinely receives updated performance data and analysis. Using this, it then agrees any necessary actions under the oversight of the board. This is a robust process. The police have been challenged to support the data that they provide with an analysis. The newly procured sexual health service has been asked to provide data about young people who attend its service. The board receives detailed information about children at risk of child sexual exploitation and from going missing. It has recognised that it could helpfully focus on some additional vulnerable groups. Children looked after, particularly those who live outside the local authority boundary or who are involved in offending, are a vulnerable group whose welfare has not received the same rigorous scrutiny. (Recommendation)

109. There is a robust multi-agency auditing framework in place. Three such audits are carried out each year. Audit topics are informed by the board's priorities. The last three have been children at risk of sexual exploitation, children who harm children and children experiencing neglect. The audit process is independently chaired and the methodology is robust. Audits undertaken by partner agencies are also reported to the board. This includes regular reports about the quality of early help. A recent audit showed that when practitioners have had recent training, the quality of CAFs improved. This led to a board challenge to the early help partnership about the sufficiency of CAF training.

110. The TWSCB Section 11 audit of how agencies are complying with their statutory duty to safeguard children has been enhanced. Partners now report on service improvements informed by consultation with children. Schools are asked about how they have integrated safeguarding into the curriculum. This has significantly improved their engagement with this process. The outcome of the audit is subject to a very effective ongoing peer review process. This

involves testing the outcomes with managers and practitioners employed by the agencies concerned.

111. The board is an influential participant in planning services for children and young people. It also drives awareness-raising activity about important issues across the partnership and particularly in schools. These include domestic abuse, 'sexting' and child sexual exploitation. A safeguarding education group has recently been set up to ensure the continuing successful roll out of these initiatives across schools and further education settings.

112. The board has been influential in driving the implementation of the 'Neglect' strategy. This has involved the introduction of the 'child's lived experience' (CLE) model and the introduction of the graded care profile (GCP). Both of these evidence-based approaches support the identification and assessment of neglect. The TWSCB multi-agency audit of work with children suffering neglect showed positive outcomes for the children involved in the CLE pilot. This informed its roll out. A further evaluation of how well this model has been embedded in practice will be carried out in December 2016. The GCP will be subject to a similar evaluation when implemented.

113. Children who go missing or who are at risk of child sexual exploitation, female genital mutilation, honour-based violence or forced marriage fall within the remit of the child exploitation (CE) thematic sub-group. Partnership working to tackle child sexual exploitation is strong. The board has also provided recent multi-agency training about female genital mutilation. However, the board's online policies and procedures do not include clear up-to-date service pathways for children and young people at risk of female genital mutilation, honour-based violence or forced marriage, to ensure they are effectively identified, protected and supported. (Recommendation)

114. The domestic abuse sub-group oversees an improving programme of awareness raising about domestic abuse and its impact. It has recently reviewed the sufficiency of victim support services. As a result, it has highlighted to agencies the lack of a voluntary perpetrator programme.

115. A thematic sub-group on children harming children has been created. This was based on learning from a MAPPA discretionary serious case review. The sub-group has led to improvements in the conduct of child protection strategy meetings and a review of the children harming children pathway. It is also involved in a project aimed at developing a strategic framework for dealing with harmful sexual behaviour between children. This framework was launched at a themed training event in May 2016. This is positive but implementation is at too early a stage to have had a significant impact.

116. The TWSCB learning and improvement framework and the training strategy are succinct, clear documents. They are both in line with the requirements of

'Working together to safeguard children' (2015). A wide-ranging and coordinated training programme is in place. This is informed by learning from a variety of sources, including local and national case reviews. It is targeted to reflect the board's priorities. A training group that reports to the partnership development sub-group has developed a post-training evaluation of impact on practice. This helpful development was only in the early days of its application at the time of the inspection. So, it had not had a significant impact on improving the quality and targeting of training. However, despite the board's 'One minute briefing' bulletins, ongoing training programme and themed training events, a few social workers spoken to did not have a clear knowledge either of the role of the TWSCB or of important learning from local serious case reviews (SCRs).

117. There is a well-functioning child death overview panel. This is a joint panel with Shropshire. Learning from child deaths, both locally and nationally, has led to training and public information campaigns about such issues as safer sleeping and suffocation from nappy sacks. Learning from perinatal deaths led directly to the establishment of a dedicated midwifery post to work with vulnerable mothers. A bereavement midwife and health visitor support families who have experienced a sudden infant death. An increase in suicides and self-harm has led to a suicide prevention strategy. This aims to improve the support available in schools and through GPs to vulnerable young people.

118. The safeguarding review and learning sub-group appropriately discharges its responsibilities regarding serious case reviews. Actions regarding the last two SCRs published are now almost complete. The partnership development sub-group oversees policies and procedures and keeps them under review. This is well managed through a joint contract with Shropshire, Herefordshire and Worcestershire local authorities. The content of the Telford and Wrekin threshold document, 'The child's journey', is generally clear and appropriate. It is a helpful guide for professionals making or handling a referral. However, it is not fully compliant with statutory guidance. This is due to a lack of sufficient clarity about the distinction between children in need and those in receipt of early help, and a small number of other omissions. The document lacks enough detail about the thresholds at which it is appropriate to accommodate a child under Section 20 of the Children Act 1989 or to apply for a care order under Section.31. The document does not link clearly enough to guidance on child sexual exploitation, as expected by 'Working together 2015'. However, because the board evaluates the application of thresholds through regular audits, this lack of clarity has not negatively affected practice. Despite this, it is important that the document fully delivers the expectations of statutory guidance. (Recommendation)

Listening to children is a key board priority. The team safeguarding voice (TSV) initiative is now rolled out to 30 schools. This is successfully raising awareness about safeguarding issues. It also provides a good process for consulting with young people, for example about the early help strategy and

the recent review of child sexual exploitation. The annual 'Crucial crew' event shows the difference that TSV is making to the level of awareness that children who attend these schools have about a range of issues. This includes such issues as personal safety, child sexual exploitation, bullying and 'sexting'. The police cadets have worked actively with the board to improve the quality of its website. A police cadet leader is one of the board's three lay members. The annual 'Health watch' survey undertaken in secondary schools focused on young people's mental health. It is planned that next year's survey is enhanced to include specific questions relating to safeguarding.

Information about this inspection

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

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

The inspection team

Lead inspector: Dominic Stevens

Deputy lead inspector: Jenny Turnross

Team inspectors: Lisa Summers, Margaret Burke, Jon Bowman, Lolly Rascagneres, Carolyn Spray, Rosemary Chapman and Ian Young

Senior data analyst: Stewart Hartshorne

Quality assurance manager: Nicholas McMullen

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

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

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

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

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

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