Arolygiaeth Gofal
Cymru
Care Inspectorate
Wales

Inspection of Children's Services Blaenau Gwent County Borough Council

June 2018

Mae’r ddogfen yma hefyd ar gael yn Gymraeg.
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Introduction

Care Inspectorate Wales (CIW) undertook an inspection of services for children in Blaenau Gwent County Borough Council (BGCBC) during February and March 2018.

Our approach to the inspection was underpinned by the eight well-being statements and associated well-being outcomes as outlined in the Welsh Government's *National Outcomes Framework for People who need Care and Support and for Carers who need Support* (March 2016). Our approach builds upon the associated local authority quality standards set out in the *Code of Practice in Relation to Measuring Social Services Performance issued under section 145 of the Social Services and Well-being (Wales) Act.* In addition, the inspection considered the local authority's capacity to improve through an analysis of the leadership and governance of its social services functions.

This inspection focused on the effectiveness of local authority services and arrangements to help and protect children and their families. The scope of the inspection included:

- the experience and progress of children on the edge of care, children looked after and care leavers including the quality and impact of prevention services, the effectiveness of decision-making, care and support and pathway planning
- the arrangements for permanence for children who are looked after and children who return home including the use of fostering, residential care and out of local authority area placements
- adherence to fostering service regulation and national minimum standards
- the quality of leadership, corporate parenting and governance arrangements in place to determine, develop and support service sufficiency and delivery particularly in relation to looked after children, care leavers and their families.

While the main focus of the inspection was on the progress and experience of children and young people looked after and care leaver's transition into adulthood, the inspection included a focus on children, young people and their family's engagement with:

- Information, advice or assistance (IAA), preventative services;
- Assessment /reassessment of needs for care and support and care and support planning;
- Child protection enquiries, procedures, urgent protective action, care and support protection plans.

Inspectors read case files, interviewed staff and administered a staff survey, interviewed managers, and professionals from partner agencies. Inspectors talked to children and their families wherever possible. Young people and care leavers attended two focus groups.

Overview of findings

- We found BGCBC has a committed workforce who are responding to an increasing workload both in terms of complexity and volume. BGCBC's self assessment described the current rate of increase in looked after children numbers as unsustainable from a workforce and budgetary position.

- There has been increasing demand to assess connected persons (or kinship placements) and in the last five years the number of 'mainstream' foster placements has been largely unchanged. This has partly been a consequence of prioritising the resourcing of connected person's assessments at the expense of mainstream carer assessments. In turn, there has been an increased reliance on independent foster agency placements and out of area placements.

- BGCBC therefore has had to face a number of significant challenges related to placement sufficiency. This means children and young people have had reduced placement choice, limiting suitably matched placement options and increasingly resulting in being accommodated in placements outside their community.

- BGCBC has responded to these issues on a number of levels. Notably, a foster carer recruitment officer has been appointed and there are plans to appoint four additional professional carers who will accommodate children and young people with complex needs and provide parent and baby placements.

- The local authority has discharged its leadership and corporate parenting roles and responsibilities and promoted the stability, safety and wellbeing and safety of looked after children and care leavers. BGCBC has a stable management group that staff regarded as approachable and supportive. We found high aspirations for looked after children was generally shared by partner agencies.

- Children, young people and families experienced timely interventions through access to appropriate information, advice and, where appropriate, assessment of need for care and support.

- We found, however, the interface between multi-agency early intervention and preventative services and statutory services to be inconsistent. The transition of family cases between services was characterised by miscommunication and referrers were uncertain about the outcome to their referral.

- Assessments were not always underpinned by a clear and recorded professional analysis of a child's needs and outcomes. The identification and management of risk of harm was not always informed

by historical and current context, likelihood of change within the family or by research and best practice.

- BGCBC demonstrated it values and empowered children, young people and their families to have an effective voice and to engage meaningfully in assessments, decisions and plans. This was not always evident in the way BGCBC staff recorded case work.

- Children and young people were protected through effective application of multi-agency safeguarding and child protection thresholds. We were concerned, however, that the capacity of the police to respond promptly to the requirement to hold a strategy discussion, regularly resulted in delay in decision making.

- Care and support planning for looked after children was varied in quality. We found plans that were effective in identifying and responding to the needs and experience of children and young people and some inconsistent plans that were not always underpinned by an updated assessment.

- Plans to make permanent arrangements for children and young people were effectively and regularly reviewed by Independent Reviewing Officers.

- We found examples of children and young people benefiting from living in safe and stable placements that met their needs.

- BGCBC worked well with partners and acted as a reasonable parent to ensure young people preparing to leave or who had left care, received effective support and help to assist them make a successful transition to adulthood.

Areas for development

Leadership, management and governance

1. BGCBC has a number of key policies, procedures and strategies to finalise and implement. These are essential to guide practice and set clear expectations for the workforce.

2. The Complex Needs Panel is underdeveloped both in terms of the cases considered and the contribution of partner agencies. The terms of reference of the panel needs to be revised to be compliant with regulation and to ensure a comprehensive quality assurance process is in place in respect of commissioned placements.

3. BGCBC would benefit from an overarching quality assurance framework to enable coordinated audit and monitoring activity to regularly challenge and support operational multi-agency practice.

Access arrangements: Information, Advice and Assistance

4. On–going work on thresholds for intervention across services is required to improve the interface between early and preventative services and statutory services to ensure children and young people's needs are consistently met.

Assessment

5. The quality of assessments needs to be improved to demonstrate a full consideration of need and a clear record of analysis of the child's needs and wellbeing outcomes.

6. Further development is required in embedding the risk management model staff had received training on. BGCBC needs to ensure social workers work to a model that facilitates skilled relationship building with families.

Care and support and pathway planning

7. The use of contract of expectations should be promptly reviewed by the Head of Service to be reassured children's safety is not being compromised.

8. BGCBC needs to ensure assessment and planning evidences active participation of families in the co-production of care and support plans and records this in a way that demonstrates co-construction of solutions to addressing need and risk.

Safeguarding

9. BGCBC, Gwent Police and partners should work together to ensure all strategy discussions are happening at the earliest opportunity and within 24 hours of the decision to hold it. This work must ensure children's safety is not being compromised.

Next steps

CIW expects BGCBC to consider the areas identified for development and take appropriate actions to address and improve these areas. CIW will monitor progress through its on-going engagement activity with the local authority.

1. Access arrangements: Information, Advice and Assistance

What we expect to see
The authority works with partner organisations to develop, understand, co-ordinate, keep up to date and make best use of statutory, voluntary and private sector information, assistance and advice resources available in their area. All people, including carers, have access to comprehensive information about services and get prompt advice and support, including information about their eligibility and what they can expect by way of response from the service. Arrangements are effective in delaying or preventing the need for care and support. People are aware of and can easily make use of key points of contact. The service listens to people and begins with a focus on what matters to them. Effective signposting and referring provides people with choice about support and services available in their locality, particularly preventative services. Access arrangements to statutory social services provision are understood by partners and the people engaging with the service are operating effectively.

Summary of findings

1.1. To meet the requirements of the Social Services and Well Being (Wales) Act 2014 (SSWBA) BGCBC has developed an Information, Assistance and Advice (IAA) service. A member of staff from the Family Information Service and Families First staff sits in the IAA team. This provides good conditions for efficient and prompt communication. The Families First service has been restructured recently. Its manager is a qualified social worker, who also manages the Team Around the Family. Staff recognise this post as essential in improving the interface between statutory and early and preventative services. This means families can experience continuity and improved consistency in the service they receive.

1.2. There has been considerable focus on improving the early intervention services and their interface with the statutory social work team. As well as accessing support via the IAA service, families can also self refer to Families First. Staff generally understood the process of transition between services. They commented that Families First services had changed their focus to support families with more complex issues. These were cases previously managed by the statutory child and family teams.

1.3. We found the IAA service was still being embedded and had not yet negotiated clear thresholds with partners or between teams. There were indications that thresholds were inconsistently applied and 'step-up/step-down' arrangements (covering the transition of work between services) were sometimes characterised by poor communication. Professionals were inconsistent in how they approached the issue of seeking parental consent to make a referral. A manager reported that Families First workers had raised anxiety about risk as they were not familiar working with more complex circumstances. This was

particularly an issue in case work connected to risk and older children as Families First workers were more familiar with working with younger age groups. This staff group had, however, attended a programme of training before the service went operational in April 2017 and had the support of qualified social work staff to support them in managing more complex needs. There was evidence of signposting to preventative services by IAA service but more input was needed with other agencies (schools in particular) to be clear about which children and families should be referred for support. This lack of clarity has potential to delay access to services for families or unnecessarily add to the workload of social work teams where families may be more appropriately supported by other services. Management oversight of the IAA service has been an issue and it is too early to determine if new management arrangements will resolve this issue.

1.4. We saw a mixed picture in how effectively services worked together. In some of the case files we reviewed the level of need was not clearly identified and consistently addressed. Sometimes a full assessment of need was not undertaken despite the presenting referral information and historical detail indicating this was required. The IAA team demonstrated an overreliance on self reporting from the parent involved in an incident or allegation and dismissed the requirement to fully corroborate explanations and seek children's perspectives. This means BGCBC cannot be sure children and young people who need care and support receive this.

1.5. Some professionals were well placed to help improve inter-disciplinary working, notably those that worked closely with schools. On the whole children and families experienced positive outcomes; however improved management oversight and a more thorough gathering and analysis of information at an earlier stage may have led to improved outcomes.

1.6. The sustainability of the range of early intervention services is mainly dependent on short term grant funding. Concerns about this were raised by several managers as presenting a problem in the continuity and further development of early intervention services that are mainly reliant on grant funding and bound by grant restrictions.

2. Assessment

What we expect to see
All people entitled to an assessment of their care and support needs receive one in their preferred language. All carers who appear to have support needs are offered a carer's needs assessment, regardless of the type of care provided, their financial means or the level of support that may be needed. People experience a timely assessment of their needs which promotes their independence and ability to exercise choice. Assessments have regard to the personal outcomes and views, wishes and feelings of the person subject of the assessment and that of relevant others including those with parental responsibility. This is in so far as is reasonably practicable and consistent with promoting their wellbeing and safety and that of others. Assessments provide a clear understanding of what will happen next and results in a plan relevant to identified needs. Recommended actions, designed to achieve the outcomes that matter to people, are identified and include all those that can be met through community based or preventative services as well as specialist provision.

Summary of findings

2.1. Assessments seen were of variable quality. We found case files did not routinely record clear evidence of how access to services was determined or why the case was determined as appropriate for Family First or statutory services. The assessments seen did not consistently address issues of risk. While the history of the child was sought, the record did not show how it was analysed to inform the decision or the weight given to the issues identified. This means relevant patterns or historical trends may be overlooked leading to poor decision making.

2.2. There was evidence of some thorough and insightful assessments which analysed strengths and risks and led to good outcomes. We identified a case where social workers responded to a child protection referral with the extended family rapidly engaged to contribute to the care and support plan. Families First and Flying Start services were utilised to assist the family. This case illustrated how the social worker had communicated effectively with the family, who were clear what was required from them to allow the child to remain at home with plans reflecting the family's ability to change.

2.3. There was evidence of assessment being undertaken in a timely manner and care and support plans being reviewed in accordance with requirements. For example, in response to a referral from Tai Calon (Community Housing) about poor home conditions a home visit was immediately made and a meeting promptly convened which was attended by relevant professionals. We recognised the professional quality of the work undertaken to address parents' initial suspicions. This family was then 'stepped down' to early and preventative services which helped sustain changes.

2.4. However assessments did not always evidence the weight given to the information collected or why a decision on a case was determined. Assessments were therefore not always underpinned by a clear recorded professional analysis of the child's needs and wellbeing outcomes. Strengths and barriers were not well defined and the voice of the child was sometimes lost in jargon and formulaic language. When asked about some of the wording in the assessments, social workers were clear they were written in this style in case of court action. This has the potential to drive antagonistic working relationships with families and unnecessary recourse to statutory process.

2.5. This was illustrated in some case work when historical involvement or a history of poor cooperation was considered a reason to instigate a statutory social work response rather than family support, despite long periods where families had managed without any professional intervention. Further work is required to define and co-produce the personal well-being outcomes people wish to achieve. The Head of Service has accepted that court led thinking may be driving case decisions leading to more cases being brought before the court. This has potential to create a legal and risk averse mind-set.

2.6. We found a contract of expectations was regularly used to complement care and support plans on cases open to social workers. These can be helpful when clarifying and communicating concerns to support a child protection care and support plan; however we found they were written as a list of expectations of things parents had to adhere to that provided no reassurance about safety. We saw examples where contracts were used where it would have been more appropriate to follow child protection procedures. This has potential to place children and young people at risk of harm.

2.7. We did not see evidence that assessments were routinely updated to reflect changing need even when there was significant ongoing involvement. Nor were assessments being routinely shared with people and there was lack of clarity in recordings about parental consent. Feedback to referrers was also inconsistent.

3. Care and support and pathway planning

What we expect to see
People experience timely and effective multi-agency care, support, help and protection where appropriate. People using services are supported by care and support plans which promote their independence, choice and wellbeing, help keep them safe and reflect the outcomes that are important to them. People are helped to develop their abilities and overcome barriers to social inclusion.

Summary of findings

3.1. BGCBC has locality teams that cover Tredegar, Ebbw Vale, Abertillery and Brynmawr. It was envisaged the establishment of the teams would reduce the number of changes of social workers working with families compared to the old team structures. Managers told us they had anticipated the new structures would increase time available to work directly with families. In reality this has not happened as the volume of work and processes had detracted from doing this. However, staff were positive about the new Supporting Change Team which was set up at the end of 2017. This should enable social workers to use their skills to work directly with families.

3.2. Children and young people's care and support plans were supported by partner agencies when required and were reviewed in a timely manner. Performance data indicated timeliness of child protection conferences and looked after children reviews were of high standard. This is significant as it means the needs and safety of children and young people are regularly considered by a multi-agency group.

3.3. The forms used for care and support planning were not effective as Care and Support plans, did not flow from the assessments and were consistently list and task driven. For example, a parent with mental health problems was given a list of tasks to achieve as part of a care and support protection plan to demonstrate co-operation. The plan did not reflect the significance or weight attached to each of the actions and the consequence of not meeting them for the child. The record did not reflect how agencies supported the parent to carry out these tasks although some significant work was carried out. This case was at risk of escalating as the outcomes required were not sufficiently clear, did not record what worked or did not work and what would happen next.

3.4. Care and support plans, including those for child protection, would benefit from a clearer focus on outcomes. Peoples' views of their assessment and plans were not generally included. There was limited evidence on files of the views, wishes and feelings of the family. In some cases there was no evidence that plans were shared with families. This means families and partners may not know what is expected of them with uncertainty about time scales.

Care Leavers

3.5. Care leavers can be confident the local authority supports their transition to adulthood in providing practical, emotional and financial support until they are at least 21 and, where necessary until they are 25. Overall pathway plans we reviewed were in accordance with requirements. Overwhelmingly the young people who were interviewed were positive about the type of help they received and the availability of their personal assistant (PA). The co-location of the PA within the 14 Plus team helped continuity and communication between team members. The team's office base was being redeveloped at the time of inspection to provide facilities adjacent to enable young people to develop their independent living skills.

3.6. Good working relationships and effective joint working was recognised between social workers and housing staff, with clear understanding of each others roles and responsibilities. This was reinforced through the leadership of key managers. A Youth and Temporary Accommodation Officer post had a particular focus on supporting care leavers and homeless young people. This worker provided advice and was a link to the IAA service as well as working closely with the 14 plus team. The authority has developed some limited supported accommodation for young people that has floating support, and is working with housing associations regarding wrap around support schemes and more intensive family intervention projects. Housing staff were represented at the Corporate Parenting Board and the board has a sub group focused on accommodation needs. This has resulted in positive joint working and means young people leaving care or at risk of homelessness receive effective support and help to assist them make a successful transition to adulthood.

3.7. Social workers talked about good inter-disciplinary support from Coleg Gwent. An information sharing protocol had been developed with the college and college staff attending the 14 Plus team meetings. Social workers acknowledged close working relationships with staff from the Additional Learning Team and Inspire Team at Coleg Gwent had helped to develop less risk averse responses and resulted in improved opportunities to engage young people in education and training.

3.8. The 14 Plus team had a cohort of young people who had been assessed as at risk of potential child sexual exploitation (CSE). The corporate parenting board had tracked a sample of cases and demonstrated risk was reduced over time. Assessments were clear and provided evidence of joint work with specialist services such as drug agencies, health and police to identify high risk individuals. We saw evidence of good analysis and realistic plans that included the young person's wishes and feelings. For example, close working with

police led a young person known to the police being identified as a vulnerable adult. Police attended multi- agency meetings and this prevented the need for a harder line policing approach.

3.9. Children and Adult services integrated their disability teams in April 2017, with single line management. This was considered to have had a positive impact on transition of disabled young people between services, with improved consistency and better focus on issues arising from transition to adulthood.

Permanency Planning

3.10. Notwithstanding the problems identified in limited placement availability we found children and young people benefited from living in safe and stable placements and accommodation that meets their needs. A long standing and stable placement of a young person placed with foster carers was subject to *When I am Ready* (WIR) arrangements, the young person was planning to go to university. A young person placed out of the county area was living securely with carers. Reviews were well attended by both health and education partners reflecting the corporate commitment to this young person.

3.11. We met with a group of looked after children who described exceptional examples of very supportive foster placements. They described positive experiences of foster carers who provided lots of social opportunities, considered them part of a family and helped them feel listened to. This had resulted in good attachment with their carers. Placement stability was therefore excellent for these children who had medium or long term placements in foster care. Case file auditing and interviews with foster carers corroborated that looked after children placements were suitable and stable with children achieving good outcomes since living with foster carers. Foster carers reported they generally felt supported by their supervising social workers. This is important as this provides opportunity to address placement challenges and ensures placements are secure for children and young people.

Placement choice, stability and wellbeing

3.12. BGCBC has processes in place to meet the demands of the Public Law Outline (PLO), court expectations and timescales which are routinely met, notwithstanding the pressures this then places elsewhere in the system. Local authority lawyers have been working with depleted resources and this has resulted in legal case work being outsourced to private firms. The *Re.B* meetings which BGCBC convenes pre final hearing when determining a permanency plan for a child were viewed as effective by social workers.

3.13. BGCBC told us the legal profile of their looked after children population had changed reflecting judicial expectations. BGCBC

performance data indicated there had been a 75% increase in both 'Placement with Parent' and connected person placements in the five years leading up to 2018. The Family Placement Team has had challenges in recruiting mainstream carers; in five years the number of mainstream foster care placements has remained largely unchanged despite the number of looked after children increasing by nearly one hundred in the same period. We identified cases where the designation of the placement was attributed to judicial expectations with social workers directed to formally assess connected persons. This has resulted in BGCBC having limited capacity to undertake mainstream foster carer assessments.

3.14. BGCBC has recognised it needs to review the terms of reference of its Complex Needs Panel. The panel does not receive timely cases on to the agenda and the membership is inconsistent. There is no quality assurance of commissioned placements nor clear understanding of the outcomes being achieved for children and young people. Some complex needs assessments reviewed during the inspection were not routinely updated and there was no evidence of quality assurance of provision. For example, a child had been placed outside of BGCBC area and whilst the local authority where the child was placed had been notified, the complex need panel minutes provided no detail nor clarity regarding the suitability of the placement. An assessment of the child had not been updated prior to placement despite four previous placement breakdowns. This means that the Complex Needs Panel process does not provide reassurance all young people with complex needs living away from their own community are living in appropriate homes.

3.15. The authority receives notifications about placements from other local authorities within BGCBC. These included basic details but did not include information about risk or a copy of the care and support plan. Notifications when placements ended were not always provided. In one case, a neighbouring authority maintained case management accountability but given periods of absconding in the local area, a risk assessment on the BGCBC file would have helped local professionals in managing and mitigating risks to the young person.

3.16. BGCBC has an established process for the commissioning of placements. We found the Placement Co-ordinator played an important role in this process and had developed knowledge and intelligence about providers. However lack of placement choice was a significant issue; this meant urgent searches following a placement request regularly resulted in no match with an increased reliance on the independent foster agency market and placements out of the county boundary. In response BGCBC is piloting a scheme to recruit specialist professional foster carers to accommodate children with complex needs and to provide parent and baby placements.

3.17. BGCBC’s Corporate Parenting Board (CPB) is an active and productive forum. Since 2015 this has been chaired by the Head of Service and meets on a quarterly basis. Two sub groups work to an annual action plan with a focus on accommodation and education, training and employment. Most recently the CPB has completed work to raise awareness with children and young people on internet safety and self-harm.

Participation

3.18. BGCBC has commissioned NYAS to conduct a young people’s survey in relation to the CPB action plan and the Children’s Commissioner for Wales *Hidden Ambitions* report. This is due to be published later in 2018. Since June 2017 BGCBC is one of four Gwent authorities to develop a regionally commissioned advocacy and Independent Visitor service. BGCBC ensures every child who becomes looked after will meet with an independent advocate. We found NYAS was actively working with children and young people and the views of children and young people was being represented by their active participation, as appropriate, in looked after children reviews.

4. Safeguarding

What we expect to see
Effective local safeguarding strategies combine both preventative and protective elements. Where people are experiencing or are at risk of abuse neglect or harm, they receive urgent, well-coordinated multi-agency responses. Actions arising from risk management or safety plans are successful in reducing actual or potential risk. People are not left in unsafe or dangerous environments. Policies and procedures in relation to safeguarding and protection are well understood and embedded and contribute to a timely and proportionate response to presenting concerns. The local authority and its partners sponsor a learning culture where change to and improvement of professional performance and agency behaviours can be explored in an open and constructive manner.

Summary of findings

4.1. We found children and young people were protected through effective application of safeguarding and child protection thresholds. We identified some good examples of child protection practice and some examples where the thinking and decision making lacked the depth necessary for robust practice. This could partly be attributed to practice being focused on gathering and preparing court evidence and formalised process. The use of Section 76 status was described as becoming more formalised across the service led by the expectations set by the court that if a child has not been rehabilitated home by the 2nd Looked After Children Review (at 4 months) then the matter should be put before the court. There was also a requirement that permanency planning needed to rapidly establish the feasibility of children returning home. This approach was said to have impacted on permanency planning and was reflected in numbers of children who were placed at home or with relatives on a Care Order.

4.2. The Head of Service described an eclectic approach to working with families. We spoke to social workers who were fully committed to working effectively with families but there was a lack of clear methodologies on how to build relationships with families, partly as a consequence of the task driven focus of court work. All staff had been trained on the Bruce Thornton Risk Assessment Model, managers recognised this had not been implemented effectively across the workforce and therefore the model had not been embedded in practice.

4.3. BGCBC works with partners to ensure those involved with the service receive a timely assessment. New safeguarding cases were identified and managed mainly in a timely manner. We identified prompt response to child protection referrals and resulting child protection enquiry responses involving partner agencies and family. Proportionate assessments were undertaken within 24 hours. There

was evidence of early identification of risk and appropriate actions taken.

4.4. Safeguarding thresholds, however, were inconsistently applied. This was exacerbated with some partner agencies misunderstanding child protection case context and therefore inappropriate referrals were being made to statutory services. School staff had received extensive training on safeguarding via the Education Safeguarding Manager, yet there remained confusion about effective inter-agency working.

4.5. In responding to child protection referrals we found children and young people's immediate safety was not always assured through effective multi-agency arrangements. Social work staff indicated that although the police in the Police Protection Unit could be helpful, police capacity issues created delays in responding promptly to child protection concerns. In relation to holding strategy discussions, the local authority was given a time slot by the police within 24 hours of the request (unless urgent when the Detective Sergeant would respond). Case files reviewed showed minimal joint investigation, although staff gave examples of this happening. Delay at key information sharing and decision making points, notably strategy discussions, has the potential to place children and young people at on going risk of harm.

4.6. There was evidence of good practice in responding to young people who had been reported as missing (MISP). BGCBC reported whilst the overall numbers of children reported as missing was a small percentage of the looked after children population, those who do go missing had done so on a number of occasions. All safe return interviews were reported as being completed within 72 hours of the young person's return. These are undertaken by independent workers from Gwent's dedicated Missing Children Team. This multiagency team monitors missing episodes and shares information collected as part of their risk assessments.

4.7. Social workers told us reduced business support resource meant child protection case conference minutes and plans were often delayed in being logged on the system. The burden of increased administrative work being undertaken by social workers has been recognised by BGCBC senior managers, however, the authority does not have a planned solution. This means important case information can be missing from the system which can impact on safeguarding practice and people's safety.

4.8. We recognised some positive outcomes identified through the use of the statutory and court process. A case involving parental substance misuse resulted in a timely pre-birth plan being developed and the child able to return home to parents. The child initially lived with extended family prior to moving to the parental home following an assessment period when the parents had proven a capacity to

change in order to parent safely. This demonstrated how high risks can be effectively managed through detailed care and support planning.

5. Leadership, management and governance

What we expect to see
Leadership, management and governance arrangements comply with statutory guidance and together establish an effective strategy for the delivery of good quality services and outcomes for people. Meeting people's needs for quality services are a clear focus for councilors, managers and staff. Services are well-led, direction is clear and the leadership of change is strong. Roles and responsibilities throughout the organisation are clear. The authority works with partners to deliver help, care and support for people and fulfils its corporate parenting responsibilities. Involvement of local people is effective. Leaders, managers and elected members have sufficient knowledge and understanding of practice and performance to enable them to discharge their responsibilities effectively.

Summary of findings

5.1. We found BGCBC has established clear lines of accountability and governance. The authority has a high proportion of newly elected members, but members and senior officers worked together and with partners to provide stable leadership and clear strategic direction for the development and delivery of children's services. The priority afforded to children's services was evident including for looked after children and care leavers.

5.2. The key strategic focus is set out in the 2017-20, *Safe Looked After Children Reduction Strategy*. This also outlines how families are able to access early intervention to reduce the need for statutory interventions as well the escalation of concerns that result in children becoming looked after.

5.3. We found management oversight of front line practice was effective and senior managers were sighted on current service pressures. Managers were familiar with individual assessments and care and support plans, but this was not always evident in the case files nor was it clear what had worked well or not.

5.4. Staff valued the support of managers, including senior managers who were described as approachable. We found the Head of Service had nurtured a supportive and inclusive culture. Supervision was viewed positively following a turbulent period in 2016 when there were a number of acute workforce challenges that affected the quality and frequency of supervision. We found the workforce to be committed to safeguarding and protection of children and young people in the borough and to working for BGCBC. This was corroborated by workforce data. Although some teams were experiencing current vacancies, BGCBC has reported low staff turnover; 1.3% turnover at the end of quarter 3 for 2017/18. BGCBC also report that 80% of looked after children had not experienced a change of social worker in the past 6 months.

Methodology

Self assessment
BGCBC completed a self assessment in advance of the fieldwork. The authority was asked to provide evidence against '*what we expect*' under each key dimension inspected. The information was used to shape the detailed lines of enquiry for the inspection.

Fieldwork
We selected case files for tracking and review from a sample of cases. In total 56 case files were reviewed; of these 18 were followed up with tracking interviews with social workers and family members and 4 were subject to a tracking focus group. The latter was a focus group comprised the professionals working with that family.

We interviewed, children, parents and relatives.

We interviewed a range of local authority employees, members, senior officers, Director of Social Services and the BGCBC managing director.

We interviewed a range of partner organisations, representing both statutory and third sector.

We reviewed a sample of five staff supervision files.

We looked at a sample of complaints that were made about children' services.

Inspection Team:
Lead Inspector: Michael Holding. Supporting Inspectors: Sharon Eastlake, Duncan Marshall, Ann Rowling and Katy Young.

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