Gloucestershire

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

and

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

Inspection date: 27 February to 23 March 2017

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

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

Executive summary

Overall, services for children in Gloucestershire are inadequate.

Senior leaders have not sufficiently prioritised or improved the quality of social work practice since services for children in need of help and protection were judged inadequate in 2011, and the quality of services to children and families has now deteriorated significantly. As a result, there are serious and widespread failures for children in need of help and protection.

Serious concerns about the integrity of the current senior leadership team were raised during this inspection. Inspectors discovered significant discrepancies in some information provided to them by the senior leadership team, which demonstrated that some staff feel vulnerable, unsupported by senior managers and fearful of challenging or exposing poor practice. Relationships between senior managers and practitioners have broken down. Inspection findings and staff feedback, as well as an unprecedented number of whistleblowing concerns, demonstrate that the management oversight of children's services is failing to protect children and families.

However, there is evidence of recent financial and political will to improve services for children and families that has led to a number of new developments. Nevertheless, improvements have not been swift enough and have not been robustly monitored by senior leaders to ensure that they consistently deliver improved outcomes for children. Poor relationships between managers and staff, and a high number of inexperienced social workers, coupled with a high turnover of staff, have further compounded the ability of senior leaders to deliver sustained improvement.

The quality and accuracy of performance information available to senior managers are poor and do not enable senior managers to scrutinise performance and social work practice rigorously enough. Quality assurance processes are underdeveloped and are not sufficiently well targeted or purposeful in identifying key weaknesses in practice. Audit activity has been limited, and findings from audits have not been collated effectively or used sufficiently well to drive improvement in children's services.

Management oversight is inadequate. It lacks rigour and direction. It continually fails to identify key weaknesses in social work practice or ongoing risks to children. The impact of child protection chairs and independent reviewing officers in securing better outcomes for children is limited. Key decisions and actions to support children are not pursued rigorously enough or completed in a timely manner.

Significant weaknesses in social work practice are prevalent across help and protection, and in some areas of children looked after, children are not seen early enough by social workers, and significant delays in responding to their needs mean that some children are left exposed to unassessed risk for far too long. Thresholds for access to services are not consistently applied. Assessments, decision-making and

planning for children are poor and frequently adult-focused. Case records are poorly maintained.

Children in need and child protection plans are not sufficiently clear or robust. Children experience a high number of repeat referrals and repeat child protection plans, as well as significant delays in initiating care proceedings. Strategy meetings are not always timely, and this inevitably leads to delays in child protection enquiries.

Arrangements to identify and support children at risk of sexual exploitation are an improving area of practice. However, the quality of individual casework to protect young people continues to be variable. Young people are not routinely offered a return home interview after they have been missing.

Delays in decisions to look after children mean that they do not always become looked after when they need to. However, children are visited frequently by their social workers and many receive a child-centred and sensitive service from workers who know them well. Permanency planning for children is not yet consistent and pre-proceedings work is not robust enough. Life-story work and direct work with children are effective when undertaken, but are not routinely embedded in practice.

Educational outcomes for children in care are variable, and attainment and progress at key stage 2 through to key stage 4 are too low. School attendance by children in Year 11 and above is poor, and while improvement strategies are in place, these are not yet sufficiently effective in improving attainment and attendance for children.

The local authority is in touch with the vast majority of its care leavers, who receive good support from personal advisers and access to a range of suitable accommodation. However, the local authority has not made sustained efforts to contact and keep in touch with all care leavers. The quality of pathway planning is poor. Some care leavers are placed in bed and breakfast accommodation with insufficient support, which is unacceptable. A high number of care leavers are not in employment, education or training.

Some improvements to the quality of practice are taking place. These include the strengthening of early-help services and improved commissioning arrangements. The local authority has demonstrated a significant strength in the appointment of, and subsequent learning from, the young people who form the 'ambassadors team'. They ensure that the experiences of vulnerable children and young people are highlighted and integrated well into service planning.

Stable managers in the fostering and adoption teams continue to support and develop strong practice. Early permanence to adoption is highly effective in ensuring that children are placed at their adoptive home as early as possible.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates one children's home. This home was judged to be good at its most recent Ofsted inspection.
- The last inspection of the local authority's safeguarding arrangements was in February 2012. The local authority was judged to be adequate.
- The last inspection of the local authority's services for children looked after was in November 2010. The local authority was judged to be adequate.

Local leadership

- The director of children's services (DCS) has been in post since August 2011.
- The DCS is also responsible for some services for vulnerable adults.
- The chief executive has been in post since May 2005.
- The chair of the Local Safeguarding Children Board (LSCB) has been in post since June 2014.
- The local authority has commissioned out youth support services, including youth offending and targeted support for young people, including care leavers. The commissioned youth support service (Prospects) also provides leadership and management for children in care over the age of 11 and care leavers.
- Children's centre provision is provided by a national charity and two local social enterprises.

Children living in this area

- Approximately 124,799 children and young people under the age of 18 years live in Gloucestershire. This is 20.2% of the total population in the area.
- Approximately 14.4% (at 31 August 2014) of the local authority's children aged under 16 years are living in low-income families.
- The proportion of children entitled to free school meals:
  - in primary schools is 10.83% (the national average is 14.5%)
  - in secondary schools is 7.55% (the national average is 13.2%).
- Children and young people from minority ethnic groups account for 7.7% of all children living in the area, compared with 21.5% in the country as a whole.

[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.

- The largest minority ethnic group of children and young people in the area is Mixed and Asian British.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 7.5% (the national average is 20.1%)
  - in secondary schools is 5.2% (the national average is 15.7%).

Child protection in this area

- At 28 February 2017, 7,319 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 6,062 at 31 March 2016.
- At 28 February 2017, 461 children and young people were the subject of a child protection plan. This is a reduction from 568 at 31 March 2016.
- At 28 February 2017, 19 children lived in a privately arranged fostering placement. This is an increase from 18 at 31 March 2016.
- In the two years prior to the inspection, seven serious incident notifications were submitted to Ofsted and three serious case reviews were completed by the local authority.
- There are two serious case reviews ongoing at the time of the inspection.

Children looked after in this area

- At 28 February 2017, the local authority is looking after 604 children. This is an increase from 549 at 31 March 2016. Of this number:
  - 91 (or 15%) live outside the local authority area
  - 39 live in residential children's homes, of whom 76% live out of the authority area
  - 10 live in residential special schools,[3] of whom a very small number live out of the authority area
  - 473 live with foster families, of whom 10% live out of the authority area
  - 22 live with parents, of whom a very small number live out of the authority area
  - 28 children are unaccompanied asylum-seeking children.
- In the past 12 months:
  - there have been 31 adoptions
  - 40 children became the subject of special guardianship orders

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

- 298 children ceased to be looked after, of whom 7% subsequently returned to be looked after
- 12 children and young people ceased to be looked after and moved on to independent living
- no children and young people ceased to be looked after or are now living in houses in multiple occupation.

Recommendations

1. Ensure that thresholds for services are consistently understood and applied, so that all children receive an appropriate and timely response when they need it.

2. Ensure that all work is allocated within appropriate timescales, and that consistent management oversight regularly reviews capacity and ensures that actions are implemented to safeguard children and progress their plans.

3. Ensure that assessments of children, including children looked after, are timely and proportionate, identify risk and protective factors effectively, and lead to robust and measurable plans.

4. Ensure that strategy meetings are timely and that there is effective safety planning for children prior to an initial child protection conference being held.

5. Take immediate action to ensure that the quality of management oversight and supervision are strengthened, and that the support and guidance given to social workers are clearly evidenced to enable them to progress work effectively and in a timely way. (Paragraph 30 and 112)

6. Take urgent steps to ensure that social workers and managers receive relevant child sexual exploitation training and that children who are identified as at risk of sexual exploitation are subject to a risk assessment, and offered responsive and appropriate help.

7. Ensure that all young people who go missing from home and care are offered prompt return home interviews and that the information obtained is used effectively to support their safety plans.

8. Ensure that children come into care in a planned way, whenever possible, and that prompt legal advice and immediate social work action ensure that pre-proceedings work and care proceedings are both swiftly actioned and have a demonstrable and positive impact for children.

9. Continue to improve short-term placement stability, particularly for older adolescents with complex needs, by expanding the resources and placement choice available.

10. Ensure that the importance of permanency planning is understood by all staff, particularly professionals at the 'front door', and that it is implemented in a timely way for all children.

11. Ensure that life-story work and direct work is offered within the child's timescale to help them to understand their histories and experiences.

12. Ensure that the quality assurance function and escalation process of both independent reviewing officers and child protection chairs are well embedded

and purposeful, and that their findings and challenges are well considered and acted upon to improve outcomes for children.

13. Ensure that up-to-date, accurate data is collated and analysed to support the virtual school to evaluate impact and improvement for children looked after and their educational needs.

14. Devise and implement effective strategies to reduce the number of care leavers who are not in education, employment or training, and provide Gloucestershire care leavers with opportunities for work experience, work placements and traineeships in the local authority.

15. Ensure that social workers make sustained attempts to keep in touch with all care leavers and monitor their welfare effectively, while maintaining robust case records.

16. Ensure that the quality of pathway plans is consistently good and that care leavers are actively encouraged to contribute to the content and development of these plans.

17. Ensure that in circumstances where emergency bed and breakfast accommodation is used, these arrangements are risk-assessed and that the young person is robustly monitored and supported.

18. Implement a system so that findings from reviews, audits, staff surveys, complaints and serious case reviews, and feedback from children, parents and carers, are collected, analysed, systematically actioned and regularly evaluated.

19. Improve performance information, and ensure that data is accurate and consistently well used to understand the quality of performance in localities and practice areas, and that this informs robust planning for improvement.

Summary for children and young people

- Inspectors found that services for children in Gloucestershire have deteriorated since the last inspection in February 2011. This means that children who need help and protection do not always have the right help, at the right time, to keep them safe.
- Social workers do not visit children and young people who are living with their own family regularly enough to make sure that they are safe. When they do visit children, they do not always record what the children tell them. This means that the plans that they make for children and their families are not always well informed.
- Children and young people experience too many changes of social workers. Assessments and plans need to be clearer, so that everyone knows what has to change to make things better for children.
- Senior managers do not always check that social workers are doing what they should be doing to make sure that children and families receive the help that they need quickly enough. This means that there are too many delays in families receiving help and support.
- Some children are left in unsafe situations for too long. However, once the decision has been made for them to be looked after by the local authority, the planning for their care improves. Children have better support when they live with foster carers or family members.
- Most children who are looked after by the local authority live in the same placement for a long time and have the help that they need to ensure that they are healthy and go to school regularly.
- Children whose plan is for them to be adopted are very quickly placed with families and receive a very good level of support. Adopters speak highly of the support that they receive to ensure that children and young people remain settled and live in homes that best meet their needs.
- Young people leaving care receive a service that needs to improve. They are given help to find suitable accommodation, and staff mostly keep in touch with them to provide help and support, but the quality of the written plans to help them to prepare for adult life is not good enough.
- Senior managers are aware that there is much to be done to improve the service that children receive. They accept and now understand that keeping children and young people safe must be a priority.

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

Summary

Services for children in need of help and protection are inadequate, resulting in serious and widespread failures. Children are not seen early enough by social workers, and the significant delays in responding to their needs mean that some children are left exposed to unassessed risk for far too long. Thresholds for access to services are not consistently applied. Assessments, decision-making and planning for children are poor and frequently adult-focused. Case records are poorly maintained. When children do receive help, cases are stepped down to early help or closed too soon, without evidence of sustainable change and reduced risk.

Not all work is allocated, and a lack of management oversight leaves children in situations of risk without their needs being assessed. Children's views are not always clearly evident in assessments and plans. Social workers do not always visit children regularly enough to make sure that they are safe. When they do visit children, they do not always record what the children tell them, and this contributes to delays and poor decisions to protect them.

The quality of assessments and plans is too variable. Although some are good, too many repeatedly fail to consider children's histories to ensure that all risks to children are identified. Plans are often overly optimistic about the capacity of parents to change or their ability to protect their children, particularly for those children who experience domestic abuse, parental substance misuse or the cumulative impact of neglect.

Strategy meetings are frequently delayed, and subsequent action plans are not consistently robust or measurable. There is a lack of safety planning for children between the strategy meetings and the initial child protection conferences.

The provision of early-help services is improving. The development of a clearly understood early-help pathway is seeing an increase in the number of children benefiting from early-help provision.

The quality of practice provided for children who go missing or who are at risk of child sexual exploitation, although improving, is not yet sufficiently robust for all children. Return home interviews are not always undertaken, leading to missed opportunities to engage effectively with young people. Child sexual exploitation risk assessments are not regularly updated to inform better safety planning for children.

Inspection findings

20. Inspectors found serious and widespread failures in services for children in need of help and protection. Severe weaknesses in performance monitoring, quality assurance, management oversight and the quality of social work practice have led to serious delays in assessing risk and putting plans in place to protect children. There are delays at every point of the child's journey. Current systems and processes are ineffective.

21. A significant number of children's cases seen by inspectors were referred back to the local authority in which social workers and managers had failed to identify children at risk and, in particular, to respond appropriately to escalating risks in families. This included children left at potential risk of significant harm for far too long, and who required immediate action to safeguard them.

22. Early-help services have recently been restructured and strengthened following an organisational review, in order to improve targeted interventions and increase the number of families accessing early-help provision. Services are being developed on a locality basis and are therefore becoming increasingly responsive to local need. Children's centres are now providing a service for children from birth to 11 years of age, to support families as children move into secondary school. Increasing numbers of children have an early-help plan, and social workers report that they have a clearer understanding of the services available for children and families. Multi-professional and multi-agency training has led to a more cohesive approach to assessment and planning for early help through 'my assessment, my plan and my plan plus'.

23. Initial contacts for children's social care are screened by the triage service. Most are dealt with in a timely manner, with appropriate actions being identified. However, for a number of contacts, inspectors saw delays in decision-making for children. A lack of performance data and management oversight means that the effects of delay are not recognised or managed effectively. Thresholds for services are not understood as well as they should be by practitioners, including those from other agencies. The rationale for sending some initial contacts to the multi-agency safeguarding hub is not always clear, and contributes to further delays in assessments being allocated.

24. Visits to children to assess their needs are not happening quickly enough. Local authority data for January 2017 identifies that only 60% of children are seen within appropriate timescales from referral, which leaves children in situations of unassessed risk for too long.

25. The development of a multi-agency daily meeting to consider the needs of children and families exposed to domestic violence is effective. Appropriate information-sharing and decision-making result in a coordinated partnership approach and response.

26. Child protection strategy discussions are not held soon enough when concerns about children are first identified. Delays between strategy discussions and initial child protection conferences were seen in too many cases, without adequate safety planning in place to ensure that children are protected prior to the development of a multi-agency child protection plan. (Recommendation)

27. Chronologies are not used well enough in care planning for children. Either an absence of chronologies or their ineffective use means that historical information about known risk to children does not routinely inform current planning. The impact of domestic abuse, adult substance misuse or parental mental health is not always understood or given sufficient focus in terms of the cumulative and emotional impact on children. There is an over-reliance on parental self-reporting, with insufficient challenge or consultation with partners to verify parents' accounts of events and incidents. In stronger assessments, children's views are clear and include a thorough assessment of risk with clear actions, but too many are descriptive and lack sufficient or effective analysis. (Recommendation)

28. In too many cases, management oversight is absent or weak, and lacks rigour and direction. Supervision is happening on a regular basis but, in many cases, it is not used well enough to understand children's safety and progress. Managers at all levels do not challenge poor practice. (Recommendation)

29. In some cases, children and families are not allocated a social worker for several weeks, leaving children in situations of unassessed risk. The lack of management oversight, actions not being implemented, changes in social worker and a failure to recognise and respond to children's changing circumstances contribute to children not being adequately supported or protected. At the time of the inspection, there were 47 children and young people who were unallocated within the Gloucester team. (Recommendation)

30. Social work reports about children and families that are used in child protection conferences are not always supported by current assessments and up-to-date chronologies, and many reports lack sufficient analysis of risk. This means that decisions to protect children lack rigour.

31. Advocacy is available to support children in child protection conferences, and is highly regarded as a valuable service that enables children to understand and participate in conferences. However, in some cases that were seen by inspectors, there was no evidence of any direct work with children to support their participation in child protection conferences. There is a lack of awareness among social workers of the availability of the advocacy service to support children. An absence of advocacy support for children in child protection core groups and children in need planning meetings hampers their full participation in important meetings.

32. Overall, children's plans are poor, with a lack of focus on risk and protective factors. Plans do not always contain the views of parents or children. Too many child protection plans do not identify the key risks to enable parents and professionals to be clear about what needs to change, to ensure that children are better protected and within what timescale, or the consequences if things do not improve.

33. The absence of an escalation policy impedes the ability of child protection chairs to formally challenge poor social work practice. When concerns have been raised, they have not been responded to with sufficient rigour by senior leaders. (Recommendation)

34. Processes to step up cases to statutory intervention or step down to early help are not embedded, and this has led to children not receiving an appropriate and timely service. When children cease to be the subject of a child protection plan, a child in need plan is implemented. However, in many cases, children in need plans lack rigour and are then stepped down to universal services far too early. Inspectors saw examples where a period of child protection and child in need planning had not achieved substantive change, resulting in children being re-referred within a short period of time for further help and protection. One third of child protection plans open at the time of the inspection were for children for whom this was a second or subsequent period of child protection planning. For this group of children, the previous plan had been closed too soon or the work to reduce risk had been largely ineffective.

35. Poor management oversight and an absence of a formal review process mean that some children have been subject to a child protection plan for more than two years where improvements to their circumstances were not made or sustained. There is a lack of effective challenge and action to support improvement for children who are subject to a child protection plan. In particular, there is a failure to identify at an early stage when interventions are not reducing risk for these children. In a number of cases seen by inspectors, decisions to hold legal planning meetings and consider care proceedings are significantly delayed and, when decisions are made to initiate care proceedings, there are further delays before action is taken.

36. Inconsistent attendance and participation by professionals at child protection conferences mean that there are insufficient multi-agency contributions to important discussions to help to keep children safe. Social work reports are not always shared with parents prior to a conference, which means that parents' full participation in the conference is severely limited.

37. Almost all children who are subject to a child protection or a child in need plan are visited by social workers in accordance with their plans. However, the frequency of visiting is not always consistent with the level of identified need. For some children, staff turnover has had a negative impact on children enjoying the consistency of a named, allocated worker who knows them well.

The quality of visits to children is too variable, and the wishes and feelings of children are poorly reflected in their case files.

38. In a small minority of cases, individual work with children puts their experience at the heart of the decisions being made to safeguard them. However, in too many cases the experience of children is not always known. Individual and direct work with children is only evidenced in a very few cases. Case recording does not capture the purpose of visits to children, and the visits are often too adult-focused, not individualised when children are part of a brother or sister group, and do not reflect children's cultural and diversity needs. Visits do not consistently record whether children are seen or whether they are seen alone.

39. Child protection core group meeting are mostly ineffective. Information gathered at core groups is not routinely used to inform planning and improve children's experiences. Meetings do not always occur within the required timescale. An absence of effective contingency planning, or the failure to implement plans within specified timescales, has led to drift and delay and, in some cases, delays in taking decisive action to protect children.

40. Responses to young people at risk of homelessness are appropriately assessed by the 16-plus assessment team. There is a timely response to need, and interventions are adapted to changing circumstances. Young people are accommodated by the local authority in a timely manner when their circumstances warrant such an intervention.

41. Children with disabilities receive a responsive service consistent with their level of need. The development of a birth to 25 service is still in its infancy, but it should reduce transition points for young people and their families.

42. In most cases, the response to concerns about children by the emergency duty team is proportionate to the identified risk. However, contact with children out of hours is not routinely recorded on children's case records. As a consequence, information-sharing between the out-of-hours service and daytime staff is poor and potentially puts children at risk of significant harm.

43. Managers use well-developed, thorough and carefully evaluated systems to identify and track children who are missing from education (CME). The CME team has developed close working partnerships, which it uses well, with a wide range of agencies. These include health and social care professionals, education providers and the United Kingdom Visas and Immigration Agency to locate children and their families when they go missing.

44. The quality of practice provided for children who go missing or who are at risk of child sexual exploitation is not yet sufficiently robust for all children. Not all children who have had a 'missing' episode in the past six months in which a child sexual exploitation risk is identified have a completed risk assessment.

Risk assessments are not routinely updated to inform better safety planning for children.

45. Completing return home interviews after a period of being missing is an improving picture. However, the number of completed return home interviews still remains too low. Local authority data indicates that only 41% of children reported as missing in December 2016 had a return home interview. This means that important details about what happens when children go missing are not being captured quickly enough to inform planning and support for children at risk. Where return interviews are held, in most cases, the quality of information and analysis is poor. This limits the opportunities to reduce further missing episodes. (Recommendation)

46. Multi-agency risk assessment conferences and multi-agency public protection arrangements are satisfactory, with appropriate multi-agency attendance. The safety needs of children are appropriately considered at these meetings.

47. Private fostering arrangements are mostly well identified and understood across the partnership. Awareness raising in the wider community is more limited. Some work with local schools and language schools has taken place, but this is in its infancy and is not sufficiently robust. The timeliness of visits to children who are privately fostered is variable, as is the quality of assessments.

48. Allegations against adults who work or volunteer with children are treated seriously. Tracking and information-sharing processes are in place. Allegations meetings are held, with appropriate attendees, and result in a proportionate response and relevant actions being identified.

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

Summary

Children looked after in Gloucestershire do not receive a consistently good service. A legacy of poor practice, a weak stepping-up service for children who require care following a child in need or child protection plan and increasing numbers of children looked after are challenges for the local authority.

There are delays in issuing care proceedings, and the pre-proceedings process is insufficiently robust and timely. Some children wait too long to be looked after and, as a consequence, they are left for far too long in risky situations. Of the children most recently looked after, the majority have come into care in an unplanned way, despite them and their families being known to the local authority.

Children are visited frequently by their social workers, and many receive a child-centred and sensitive service by workers who know them well. For some children, having too many changes of social worker has had an impact on their ability to build a meaningful relationship with someone who knows them well. Children do have timely care plans and reviews, but these are not consistently child-focused and do not result in improved outcomes for all children. The risks associated with children going missing from care or at risk of child sexual exploitation are known and considered, but the response is inconsistent and insufficiently thorough for each child.

Permanency planning is variable, with some children not having this considered at the earliest possible stage. However, many children do have good outcomes and live in long-term secure and stable placements.

Life-story work is of a high quality, but is not always available in a timely way. Long-term placement stability is good, including for children placed out of the authority. Short-term placement stability is improving and this needs to have continued focus, particularly for older adolescents. The fostering service is a strength, and is managed effectively with well-trained and supported foster carers. Adoption is a particular strength, with some innovative practice supporting high numbers of children being placed in permanent placements and adoption being secured for a wide range of children.

The Children in Care Council is influential and well supported to participate in a wide range of activities that improve services for children looked after and across the council.

Services for care leavers require improvement. Pathway planning and the frequency of keeping in touch with all young people are areas for improvement.

Inspection findings

49. In order to improve the experience and outcomes of children looked after, the local authority has reorganised services for children looked after. The local authority has recognised the need to address a legacy of poor practice in a number of areas, namely frequent, or inappropriate, use of section 20, poor-quality pre-proceedings and court work, poor early permanency planning, poor short-term placement stability and an absence of challenge from the independent reviewing officers (IROs). The actions to address all these concerns are starting to have an impact and real benefit for children, with work by practitioners being of a significantly better quality in the past two to three months. This has not yet reached a level where all work is consistently good for all children looked after.

50. The additional investment in a new head of service for permanence, already in post, a new additional placement team from April 2017, two additional full-time IROs and a new case-tracking manager to oversee court work indicates that senior leaders have understood the weaknesses in service provision. Although no child looked after was seen to be unsafe during the inspection, much of the work does not yet demonstrate a good, qualitative understanding of the comprehensive experience of each child.

51. The number of children looked after in Gloucestershire is increasing, overall. All children looked after require that they are kept safe and that the threshold to care is appropriate. However, there is significant drift and delay in issuing care proceedings for some children, even when this is the agreed plan, and there are delays in following up actions from pre-proceedings work, leaving some children living in risky situations for far too long. An improvement plan to address delay is only showing an impact for a small number of children, and the local authority must continue actively and assertively to drive improvements in the timeliness, quality and impact of pre-proceedings and care proceedings work. The quality of the pre-proceedings letters seen by inspectors is good. (Recommendation)

52. Currently, half of care proceedings take more than 26 weeks, with an average time of 31 weeks. The number of timely care proceedings has appropriately increased from 36% in March 2016 to 43% at the time of the inspection, ensuring that children are increasingly being better protected by a court order. The local authority has successfully reduced the number of children voluntarily accommodated under section 20 to 34%, and is working with local courts and the Children and Family Court Advisory and Support Service (Cafcass) to address a legacy of poor practice in this area. The recent implementation of a monthly meeting with Cafcass is assisting this development.

53. Most children are visited regularly and seen alone by their social worker, who knows them well and understands their wishes. This has been affected by children experiencing too many changes of social worker. Assessments and

plans consistently contain sufficient detail of children's circumstances, but vary in the quality of their recorded analysis, the children's views or the day-to-day current lived experience of children. Most work meets some of these criteria, but not much of the work meets all. This level and style of practice were also seen in child permanence reports and recent court work, which were of an adequate quality yet could be improved by increased sensitivity, analysis and attention to individual detail. However, life-story work with children is of a high quality, although not consistently timely. The impact of support, supervision and guidance from frontline managers is not always evident in assisting social workers to improve their practice. (Recommendation)

54. Children's reviews routinely take place, and care plans are updated and on file. Care plans are not sufficiently focused on the impact of children's early experiences. Consideration of permanency is not consistently considered at the earliest possible stage for each child. The local authority is aware of this, and it is a key priority in its current planning. A permanence summit in 2016, training by Cafcass and increased challenge by the IROs are starting to have some positive impact. The local authority recognises that the pace of improvement has been far too slow. As a result, a dedicated head of service for permanence has been appointed to ensure that the pace of improvement is swifter, and that consideration of permanence planning at the earliest possible stage results in consistent outcomes for all children more quickly. (Recommendation)

55. The numbers of children who return to care are reducing and are at their lowest since the local authority began measuring this indicator, but are still too high at 11%. The local authority has some services that are successfully reducing the numbers of children returning to care. For example, the diversion placement support team is a strong, effective and well-respected service for children, with professionals working hard either to prevent children becoming looked after a second time or to ensure that they return home safely. The success of the reunification project has meant that 42 of 54 children have been able to return home to family and remain at home since April 2016. A further small number of young people were able to move from residential care to foster care, where they remain.

56. An experienced designated nurse and designated consultant paediatrician for children looked after provide a good knowledge and skill base, ensuring effective multi-agency working in relation to children's health needs. An annual conference, workshops and training support practice development. The health needs of the 28 unaccompanied asylum seekers who are looked after are met through the voluntary sector's provision of 'drop-in cafes', offering translation and befriending services. All of the health needs for children looked after, including initial and review health assessments, are now coordinated by three doctors' surgeries, overseen by the designated nurse and designated doctor, providing a more consistent overview of children's health needs.

57. Some innovative practice is underway, including support regarding mental health concerns. The 'Teens in crisis' pilot, started in July 2016, offers an online counselling service for young people. This was championed by the 'young ambassadors' who spoke at the scrutiny panel in support of the idea. To date, 78 young people have accessed 260 sessions, with a waiting time of under a week, and an early evaluation is showing a positive impact on improving the emotional resilience of children.

58. Schools and designated teachers prioritise the needs of children looked after, including those children who live out of the area. Effective strategies are used to protect children from discrimination and bullying. However, only 75% of children looked after currently attend good or better schools. Children in underperforming schools receive additional direct support and monitoring by staff from the virtual school, although the effectiveness of this strategy has not been evaluated.

59. Virtual school staff are sufficiently resourced to oversee and support all children looked after. The virtual school has introduced 'Praise to progress' programmes, which recognise and reward the achievements of children, teachers and foster carers. Celebration evenings and individual children receiving handwritten cards from senior managers to recognise their attendance at school are valued and appreciated by all concerned.

60. The virtual school team works very closely and productively with school staff, and increasingly foster carers, providing training, practical support and advice that promote learning for children looked after. All school staff interviewed by inspectors were emphatic that such training had helped to improve their classroom and pastoral support practice. Virtual school staff hold regular and much appreciated good practice sessions for schools' designated teachers, and the virtual school is a trusted and valued partner. School attendance is monitored. However, strategies to improve attendance have not yet had a positive impact on children from Year 11 onwards.

61. The impact of the virtual school's intervention and support strategies is unclear, not least because progress data is unreliable. While the pupil premium is distributed efficiently to schools, its use is not measured meaningfully by schools or the virtual school, and overall it has had limited quantifiable impact. Virtual school managers recognise that just under half of the personal education plans (PEPs) produced for each child need some improvement, based only on the numbers of completed PEPs, not on the impact of intervention and support strategies. Most of the targets set in PEPs are neither specific nor measurable. The attainment of qualifications by children looked after is too low. Only a small minority of children looked after gain good GCSE qualifications at A* to C including English and mathematics. Overall, there is no evidence of sustained improvement in academic outcomes or progress over the past three years. (Recommendation)

62. No children looked after have been permanently excluded from school during the past three years. The level of fixed-term exclusions, at 15%, while reducing, is still too high. This has recently been identified as a cause for concern and the local authority needs to implement effective strategies quickly to reduce it. Four providers of alternative school provision operate across the county, and the attainment of qualifications in alternative provision is extremely low for children looked after. The proportion of children returning from alternative provision is very high in mainstream primary schools, but is only around 87% in secondary education. A new managed transition scheme has been piloted to increase the sustainability of children's return to secondary education. This is due to be rolled out in full in April 2017.

63. The local authority maintains a thorough record of children who are electively home educated (EHE). The number of EHE children is high, currently 596. Although the local authority has developed initiatives with schools to try to reduce this number, the number of children becoming EHE has risen by 20% from last year.

64. The fostering service is managed effectively, and is a strength in the organisation and continues to improve, and foster carers are well trained and supported. A busy fostering panel is appropriately chaired by an experienced independent chairperson. Foster carers understand delegated authority and are happy with the support that they receive. Although they do not consistently receive all information on children at the time when a child is placed with them, they generally consider that the service for children is improving overall, and feel valued and appreciated by the local authority. Two foster carers helpfully sit as representatives on the corporate parenting panel.

65. Social workers in the fostering service are knowledgeable. Assessments of carers, statutory checks and support for carers are generally of a good quality, and foster carer agreements, visits and foster carer training are all up to date and clearly recorded on the foster carer's file. The fostering service helpfully uses an independent person to undertake a standards of care investigation, offering independent scrutiny of assessments of foster carers. Annual reviews of foster carers are undertaken on time.

66. The local authority has had some challenges to ensure that all children receive good short-term placement stability and that there is sufficient placement choice available. This is despite the fostering team exceeding its in-year recruitment target and the helpful practice of conducting regular stability meetings for vulnerable placements. Placement initiatives, such as an extra payment to carers to be on the out-of-hours list for children over the age of 12, and the new head of permanence show current solutions to some complex issues for the local authority.

67. The use of family and friends is appropriately considered, but timeliness needs to improve. The majority of regulation 24 assessments require an extension to

the time taken for the assessment to be completed, although this is carefully overseen and monitored through the fostering panel process.

68. Despite these challenges, the local authority is able to ensure that the vast majority of children live within the county (512 of the 604 children looked after are placed within Gloucestershire) and to offer a high level of placement support to children placed out of the area. One residential manager described the social worker as 'dedicated to the child and consistently available', and that it had been one of the best placement moves to the home that she had experienced. Children with disabilities have access to a well-run short-break service.

69. The local authority has recently implemented a dedicated IRO team for children looked after. More than 100 children chair their own reviews in Gloucestershire, with some receiving a certificate for their chairing skills. Since July 2016, the IRO team has raised 120 challenges and escalations, showing an increasing awareness and confidence in the process. For example, initially many were about electronic records not being up to date, but more recently the concerns raised include delays in permanence planning, children being vulnerable in their placements and children missing from care where no action is taken to safeguard them. The impact of these challenges varies and there is still a considerable amount of work to do to maximise the impact and consistently to listen to and respect the input of this skilled and stable group within the service. (Recommendation)

70. Children who are missing or at risk of child sexual exploitation are known to the local authority, and some action is taken to consider the risk that they are exposed to. However, the response is frequently reactive and the impact is variable. Risk has reduced for some children due to the security and stability of their placement. For other children, there is an inconsistent completion of return home interviews, and these do not always contain sufficient information to reduce the likelihood of going missing again. Trigger plans are completed and on file, and do contain useful background information, but overall there needs to be a greater focus on preventative work with each child to ensure that children are consistently kept safe. (Recommendation)

71. Long-term placement stability for children looked after is an area of strength in the local authority (73% at December 2016). Many children, including large groups of brothers and sisters living together, are safe and secure, with a sense of belonging. This includes long-term fostering, where there have been 20 matches this year, and good-quality special guardianship and adoption work. Children receive high-quality life-story work, but there are delays for some children in being offered this service. (Recommendation)

72. A group of 15 'ambassadors', each with care experience, are employed by the local authority, and are highly influential and work well in partnership to improve services for children. They describe themselves as 'sweeping through the council like a storm'. They are an impressive and dynamic presence in the

council, and participate in a wide range of activities. They are involved in training and staff recruitment, as well as attendance at the corporate parenting and scrutiny panel. They offer more than the sum total of the activities and events by enhancing the emotional understanding of the organisation, by each having a dedicated focus and by being supported to share their individual experiences at the highest corporate level to staff, schools and the Local Safeguarding Children Board, and at external events.

The graded judgement for adoption performance is that it is good

73. Securing permanent families for children who need adoption is a key priority and strength in Gloucestershire. Adoption is routinely considered for all children if they are unable to live permanently with their birth family. Most children who need permanence have achieved this through adoption and, in particular, a high number of brothers and sisters are adopted together. In the 12 months prior to the inspection, 78 children had a decision to adopt. Of these, 54 were living at their adoptive home and 26 of them have an adoption order.

74. Most children with a plan for adoption find homes quickly, and move purposefully and at a pace suitable for them and their adopters. The time between the courts granting authority to place and matching to an adoptive family is 104 days in Gloucestershire, 17 days below the government threshold of 121 days. This high performance is as a direct result of the tenacity of the service in considering and achieving early permanence for adoption through 'foster to adopt' wherever possible. However, in the 12 months prior to inspection, this timescale had risen to 206 days, wholly due to the local authority's robust commitment to placing brothers and sisters together.

75. Early permanence to adoption is highly effective. The ethos and spirit of achieving early permanence permeates all the work in the adoption team. Adopters are well supported, and are asked to consider 'opting out' of 'foster to adopt' rather than 'opting in' during the assessment process. The benefits and risks of early permanence through adoption are thoroughly explored at the earliest point in the assessment. Experienced early permanent adopters influence and deliver effective support and training that result in more prospective adopters being willing to work with the uncertainty of committing to a child prior to placement order.

76. Since 2011, there have been 42 early permanence to adoptions, and in the past 12 months 22 adoption orders have been secured, ensuring that children live with their adoptive parents from the earliest possible stage of the process. All children making the transition to adoption did so from foster care, and this is managed in a sensitive and considered way, minimising the impact on

children, foster carers and adopters. The adoption panel is robust and effective. Adopters are dual approved at panel as both 'suitable to adopt' and 'suitable for early permanence placement'. The panel regularly reviews arrangements and continues to assess applicants' suitability and motivation while awaiting an appropriate match. Since 2011, five early permanence matches have not led to adoption and, in all cases, children were either appropriately returned to birth family members or achieved adoption through other successful matches. In three of the five cases, adopters have subsequently experienced a successful early permanence match and in two cases have adopted.

77. A well-established and mature adoption service benefits from knowledgeable and passionate managers and workers with a wide range of experience and skills. Practitioners in the service have extensive experience, and bring a wide range of skills and commitment, underpinned by effective and competent managers who have established a high standard of expectations and practice. This has resulted in Gloucestershire, as an adoption agency, having a good reputation locally and regionally. This helps to attract a high volume of enquiries from prospective adopters, and many return to the agency when they wish to consider adopting another child. All the adopters spoken to had experienced a very positive reception and spoke highly of the support received during the assessment process, when they were matched and after they had adopted their child.

78. A comprehensive matching risk assessment, which includes foster carers, adopters and relevant social workers, rigorously assesses the strengths and vulnerabilities of a potential placement as a response to an identified link between a child and adopter. This assessment informs a robust support plan effectively and is a key contributory factor in securing the high numbers of early permanence placements. Support plans comprehensively identify all aspects of additional resource in the short, medium and long term. These include therapeutic direct work with children, counselling and individual psychological support, according to assessed need. Adopters also access responsive therapeutic services to help them to support the work undertaken with their child.

79. Gloucestershire piloted the implementation of the adoption support fund in 2014–15, and has an established and effective process in place, with 137 successful applications to date. Support after adoption plans are comprehensive, and include extensive and resourceful packages. This enables children to form secure attachments and receive therapeutic support to help them to understand their early childhood experiences. The local authority match funds individual children to ensure the continuation of complex packages of support that include individual and enduring therapeutic support. This enables brothers and sisters, and children with complex needs, to achieve security and permanence through adoption, and it minimises disruptions. There were only two between April 2015 and March 2016.

80. Adopters are assessed and approved in an appropriate way that reflects their circumstances and experience, and this means that, for some, the process takes longer than four months at stage two. All adopters spoken to value the pace of the assessment and consider that this has enabled them to feel fully prepared for the realities of adoption. Adopters are prepared and trained to a high standard, and speak positively about the quality of communication, engagement, training and support provided by the agency. For those waiting for a suitable match, there are workshops and regular reviews to support continued engagement in the process. The most recent targeted recruitment activity and support have a focus on finding families for brothers and sisters to live together and, as a result, the number of prospective adopters reduced from 78 to 40 families by March 2016. However, this reflects the family-finding profile of children who are waiting to find permanent families.

81. An experienced adoption panel adviser provides rigorous oversight of the quality of work to the panel. The role of agency decision-maker, undertaken by three heads of service supported by good administration, provides a timely, flexible and responsive service that manages the range of adoption work effectively.

82. The adoption panel chair brings extensive knowledge of adoption and leads a suitably experienced panel effectively, including adopters and adopted adults, to bring a real perspective on the experience of children. The panel chair guides the panel to focus on strengths of the applicants, which puts applicants at their ease and enables full engagement in the panel process.

83. The panel promotes good practice and gives regular feedback to the agency about the quality of work, to inform and lead to improved practice. In particular, prospective adopter reports are insightful, analytical and strong in areas of diversity and identity, in particular single adopters and same-sex couples. Matching reports now give a real sense of why children are suitable to live with particular adopters and how they will meet the unique needs of children, now and in the future. Child permanence reports are not yet consistently of good quality. Although most seen at this inspection show sufficient understanding of the case, they lack detail, sensitivity and an inclusion of children's views.

84. Life-story work is of high quality. Those seen are detailed, age-appropriate and sensitively considered, and the use of pictorial 'toy story-books', using cartoon characters, enables younger children to have some understanding of their birth histories and supports adopters to have early conversations with children. Therapeutic life-story work using art and crafts is effective, and increasingly helps older children to explore why they are not able to live with their birth family, and helps them to make sense of, and recover from, early childhood trauma.

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

85. The overall quality and effectiveness of social workers' interventions with care leavers are variable. However, the practical help and emotional support provided enable most care leavers to develop sufficient independence skills and to build emotional resilience in preparing for adulthood. While most care leavers spoken to by inspectors now report having stable and meaningful relationships with their social workers or personal advisers, the majority of care leavers have experienced significant changes to their allocated worker over the past year. Some care leavers related how their social worker regularly went 'above and beyond' what they expected of them or 'had never given up' finding ways to support them to turn their life around.

86. The care leaver team, currently based across three accessible sites, enables care leavers to access support at a local level for information, advice and social events. Dedicated youth support workers work closely with the care leaver team, providing specialist support for mental health, sexual health, and pregnancy and parenthood concerns. An active care leavers forum provides an effective voice for care leavers to fully contribute to further improvements to their service.

87. Specialist transformational support provided by social workers to care leavers is well targeted and effective. For example, young parent care leavers are accommodated in dedicated cluster units in Gloucestershire, and these are providing high-quality, on-site parenting support. Additionally, care leavers receive good-quality responses and prompt interventions from social workers in circumstances when risk is identified. For example, responses to incidents of domestic violence or sexual abuse result in timely, effective risk assessments and joint working with relevant agencies to develop robust plans to protect the young person. This work has been further reinforced through learning from a recently published local serious case review, and arrangements to support young people in violent relationships have been strengthened as a result.

88. The local authority is in touch with the majority of its care leavers. However, 6% of care leavers had not been contacted by their social worker in the past six months or longer. Insufficient arrangements for this cohort of young people and incomplete case records do not demonstrate sustained efforts by social workers to engage with each young person. These weaknesses and the impact on the young person are not sufficiently identified or challenged by managers, and this has left some care leavers potentially vulnerable and unsupported. (Recommendation)

89. The quality and timeliness of pathway plans are variable. While pathway plans record essential information, most plans are not sufficiently aspirational and

do not reflect a comprehensive, well-rounded plan for each individual. A high number of pathway plans are completed without sufficient consideration of the young person's views or their participation. As a result, pathway plans are not valued by care leavers. While some good examples were seen by inspectors, most did not sufficiently consider the challenges experienced by the young person, for example in relation to drug or alcohol use or offending behaviour. (Recommendation)

90. Social workers provide prompt financial support for care leavers to access specialists, including therapeutic services, doctors, opticians and dentists, as and when required. Care leavers now receive 'health passports', and are aware of these and how to access their full health history. However, not enough care leavers have received a recent health assessment in the past 12 months. Case records do not sufficiently reflect attempts to encourage the young people to engage in these health assessments and, as a result, young people have not had access to timely healthcare and are not being actively encouraged to lead a healthy lifestyle.

91. Care leavers are well supported to gain a national insurance number, their original or copy birth certificate and a passport. Arrangements to help care leavers to learn basic life skills, such as budgeting and cooking, are not yet consistently enabling all care leavers to feel confident in these areas. Care leavers' attendance at the few life-skills sessions offered by the care leaver team has been low, despite sustained efforts by the team to encourage their involvement. Of care leavers over 21 years of age, 65% are now in education, training or employment and this reflects a determination to encourage second chance learning. Care leavers have a good idea of their entitlements, but the explanatory booklets are out of date. Care leavers are now contributing to the compiling of revised versions.

92. Senior managers in the care leaver team routinely analyse performance data on care leavers using a range of appropriate and informative key indicators. While this has led to some improvements across the service, the focus has not been sufficiently consistent. The quantitative and qualitative data on those who are in education, training or employment reflects that, while the local authority is aware that high numbers of care leavers are not in education, employment or training, the strategies to reduce this cohort are not always effective. (Recommendation)

93. Most care leavers do not achieve any qualifications, and only a very small minority attain good GCSEs, including English and mathematics. However, 33 care leavers are currently on degree-level courses at various universities. Care leavers have access to post-16 personal, vocational and academic development opportunities, such as taught sessions in functional skills in English and mathematics at Levels 1 and 2, but only a few achieve a qualification in these subjects. The local authority has a 'Work it Out' project, which aims to offer a range of employment pathways for care leavers, While

this has benefited some care leavers, the local authority recognises that there is developmental work needed in respect of paid employment options.

94. Most care leavers are able to access a range of good-quality accommodation in Gloucestershire. A high proportion of care leavers live in suitable accommodation and 27 care leavers are 'staying put' with their foster carers. The local authority has a good range of accommodation available to match various planned stages in care leavers' progression to independence, including transitional, supported, semi-independent, independent and temporary accommodation. Well-integrated and mostly effective arrangements are in place to allocate appropriate accommodation for care leavers. These include the effective START programme, which provides good support for young people preparing to become care leavers. Although feedback to the local authority by care leavers suggests most care leavers feel safe in their accommodation, not all care leavers spoken to by inspectors said that they felt safe in their accommodation or in Gloucestershire generally, and the reasons for this need to be explored further. (Recommendation)

95. The local authority currently lacks sufficient short-term emergency accommodation. In the six months prior to the inspection, bed and breakfast accommodation had been used for six care leavers in an emergency or at the young person's request. These arrangements are inappropriate, with insufficient systems to robustly monitor the safety and welfare of the young person. Risk assessments are not robustly completed or sufficiently recorded, and monitoring arrangements are not systematic. The local authority has identified that these arrangements require strengthening and is in the process of implementing new short-term accommodation commissioning arrangements. (Recommendation)

Leadership, management and governance	Inadequate

Summary

The leadership, management and governance of children's services in Gloucestershire are inadequate. Inspectors discovered significant discrepancies in some information provided to them by the senior leadership team, bringing into question the integrity of the leadership of children's services. Senior managers do not provide an environment in which healthy challenge is evident and social work practice is allowed to flourish, and a high number of staff reported that they feel vulnerable, unsupported by senior managers and fearful of challenging or exposing poor practice.

Senior leaders have not been swift enough to take effective action to address the widespread and serious failings in the services for children who need help and protection. The local authority has needed to take immediate action on too many cases identified at this inspection to ensure that children are safeguarded and, in some cases, to take protective action so that children are not suffering immediate harm.

A lack of a robust system to ensure that actions from case audits are consistently completed results in continuing drift and delay for children. The cases audited during this inspection highlighted that most of those for children in need of help and protection are characterised by poor identification of risk, and weak and inconsistent management oversight.

Stable managers in the fostering and adoption teams continue to support and develop stronger practice. Early permanence to adoption is highly effective in ensuring that children are placed at their adoptive home as early as possible.

The local authority and its partners demonstrate a clear commitment to a strong partnership approach to commissioning, influenced by the views of young people, that is delivering locally determined and accessible services in neighbourhood areas, making maximum use of joint resources.

Instability in the workforce is having a significant impact on the quality of practice. The turnover of social workers and managers is high. The majority of social workers have less than two years' post-qualifying experience and, for too many, the caseloads are too high and include complex cases that require a good depth of knowledge and experience. Coupled with inconsistent, weak management oversight and poor supervision, this does not support effective or high-quality help for children and families.

The focus on work to establish and support the work of the 'young ambassadors', championed by the corporate parenting board, is a good example of how young people are influential in shaping services.

Inspection findings

96. The experiences and progress for children in need of help and protection are inadequate. Services have deteriorated significantly since the last inspection in 2012. While senior managers can demonstrate that they know what needs to change, they have not been successful in delivering the changes quickly enough to address the deficits in frontline operational practice. Where they have identified weak practice and poor management oversight, the measures to make improvements have lacked rigour and pace. Consequently, a high number of cases referred to the local authority included cases where action was required either fully to understand the risks that children were exposed to or to respond appropriately to levels of risks for children. Too many children have not had their needs and risks recognised or have remained in situations of escalating and actual risk of significant harm for too long.

97. Senior leaders have not demonstrated sufficient understanding of the extent of the widespread and serious failures for children in need of help and protection, until this inspection. In all cases referred by inspectors, the local authority agreed with their findings. These included the need to take immediate safeguarding actions for compliance with child protection procedures, to progress cases through the legal framework, to reduce delays in taking action and to give a robust response to children at risk of sexual exploitation and children who go missing.

98. The director of commissioning (children and families) and the senior leadership team articulate a strong determination and commitment to improve services for children. However, an unprecedented number of staff anonymously raised concerns with the inspectors about the culture of bullying and blame that is prevalent in children's social care. Senior managers have not been able to support an environment in which healthy challenge is consistently evident and social work practice is allowed to flourish.

99. A review of safeguarding and audit arrangements was commissioned by the director in January 2017. This report highlighted that a lack of a centrally driven system prevented the local authority from having effective oversight of the impact of audit outcomes. The lack of a robust system to ensure that the actions from audits are consistently completed results in continuing drift and delay for children. Recent work to improve the robustness of audits is having some positive impact, as seen in the quality of the 20 cases identified for audit during this inspection. However, these highlighted that, for children in need of help and protection, most cases are characterised by poor identification of risk, delays in progressing assessments and plans, and weak management oversight. Senior managers have not demonstrated that they fully understand

the significance of the cumulative impact of poor-quality practice for this group of children. (Recommendation)

100. An external assessment of the independent review service in April 2016 highlighted considerable weaknesses in the quality of assessments, the quality and consistency of plans, and the absence of children's wishes and feelings to inform decisions. These features have been evident in this inspection. While the establishment of dedicated independent reviewing officers and conference chairs has been implemented, the lack of an established escalation process for child protection chairs has meant that, when concerns have been raised about the quality of practice and decision-making, there is little evidence of robust action from senior managers.

101. Frontline management oversight of practice is inconsistent and mostly poor in child protection services, and the process of auditing the quality of practice is not systematic or established enough to give an accurate understanding of the quality of frontline practice. Senior managers do not have a strong and confident assessment of the impact and experiences of children who need help and protection.

102. Frontline management for children looked after is also a weaker area of practice, although the better able and more experienced middle managers have driven improvements for children looked after, recognising where there is still more work to do. Stable and competent managers in the fostering and adoption teams continue to support and develop strong practice.

103. The local authority's and its partners' response to prioritisation and strategic oversight of child sexual exploitation is not yet leading to consistently effective practice for children at risk and those who go missing. Operational social work practice to understand the risks of child sexual exploitation is too often weak. Social workers and managers lack an understanding of the impact of child sexual exploitation and for those who go missing, and are not consistently using assessments to identify risk to inform plans to improve outcomes for these groups of children. Information from return home interviews following children going missing is not sufficiently detailed or consistently completed to enable a good understanding of the motivation behind 'missing' episodes for individual children. The lack of comprehensive aggregated information at a strategic level means that the local authority and partners do not always know the children who are most at risk in order to prioritise appropriate and effective action. (Recommendation)

104. The use of performance management data to drive improvements in key areas of practice is not consistently accurate, systematic or established across all practice areas or localities. Performance in significant areas, such as the length of time that children are on child protection plans, the number of children with second and subsequent plans and the timeliness of assessments, is not analysed sufficiently at a strategic level to understand impact or to inform and monitor improvements. Where the data focuses on cause and

effect, this is resulting in a better understanding of the issues and more effective action to address practice, for example the improved rates of young people offending and performance in the over 11s' service. (Recommendation)

105. Weekly performance reports are starting to inform managers about the strengths and performance challenges for individual teams and practitioners. However, this is not yet resulting in improved practice in some key areas. The performance data available highlights clear anomalies and practice differences between teams that do not yet trigger sufficient analysis by senior managers to prioritise improvements in either the practice areas or the geographical localities. The local authority does not yet have a performance forum to consider learning across the council that supports improved practice. Although developed, and with implementation imminent, this is a missed opportunity to pull together learning from the staff survey, complaints, serious case reviews and audits, and to demonstrate a transparent and open culture to learning and sharing of good practice.

106. There is a clear commitment to a strong partnership approach to commissioning in Gloucestershire that maximises the impact of collective resources to delivering accessible services based on a clear understanding of local need. Commissioning decisions are influenced by young people, for example 'Future in mind', that led to the establishment of the 'On your mind Gloucestershire' website. This provides accessible, confidential advice and support for young people who have emotional and mental health concerns, and includes a pilot online counselling service that is valued by young people. The new IRIS project, although not yet operational, is ambitious in addressing the safety and stability of placements for older adolescents with highly complex needs, and is a good example of effective joint commissioning.

107. Cross-party overview and scrutiny arrangements focus on key issues of performance, for example the recruitment and retention of staff, and the views of the workforce on how to improve practice. While the chief executive and lead member both have an awareness of key strengths and weaknesses across children's services, the severity of the failings in some key areas of the service had not been articulated to them sufficiently well by senior managers. Political and senior leaders have recognised the need and taken action to increase resources in children's social care, demonstrating commitment to improving the lives of children in Gloucestershire, with recent significant financial resources being made available to increase the number of frontline social workers.

108. Instability in the workforce is having a significant effect on the quality of practice. The current turnover of social workers and managers, although comparable with other local areas, is high, and this means that children are not able to form positive and lasting relationships with social workers. The majority of social workers have less than two years' post-qualifying experience and, for too many, particularly those in their assessed and supported year in employment, the caseloads are too high and include complex cases that

require a good depth of knowledge and experience. Coupled with inconsistent and weak management oversight, this does not support effective and high-quality social work practice. The quality of training provided to staff is improving. However, the evaluation of training is poor and the impact of training is not assessed effectively by managers through supervision and case audit activity.

109. The supervision of workers and managers, while taking place, does not sufficiently demonstrate clear guidance to workers to address the deficits in practice and performance, and does not provide clear expectations to complete and progress work in a timely way. Social workers' and managers' recording on case files is weak and is absent from too many children's cases, meaning that it is not always possible to tell how critical decisions regarding children's lives have been reached. Children's wishes and feelings are not consistently recorded, and do not inform assessments and plans. (Recommendation)

110. The focus on work to establish and support the work of the 'ambassadors', championed by the corporate parenting board, is a good example of how young people engage effectively and are influential in shaping services. The group of 17 young people are employed and are active participants in the corporate parenting board, scrutiny committee and commissioning arrangements. The impact of the work of the 'young ambassadors' is wide ranging, enabling key messages and their experiences to be shared effectively across the service, as well as contributing in a meaningful way to service development.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement

Executive summary

The Gloucestershire Safeguarding Children Board (GSCB) requires improvement. While it fulfils its statutory responsibilities and there is strong commitment to the work of the board from key statutory agencies, there are gaps in the board's activities and monitoring of frontline practice in children's services that limit its effectiveness.

The board is appropriately constituted and is generally well attended by key partners, including lay members. The GSCB is financially sound, with partners supporting the work of the board proportionately. The board benefits from having a respected and experienced independent chair, and the work of the board is well supported by an appropriately resourced and well-managed business unit. The chair of the GSCB is also a member of the children's partnership and has built up effective working links with the Health and Wellbeing Board and the Safeguarding Adults Board. This enables him to influence the direction of work and priority setting, such as coordinated services for those affected by domestic abuse. However, work to develop strategies and associated toolkits to address neglect and child sexual exploitation has yet to be fully embedded or effective across the partnership.

The board demonstrates open and candid challenge between board members, and this has been effective in some areas, for example in improving safeguarding practice within the multi-agency safeguarding hub. However, limited analysis and a lack of qualitative commentary on the board's dataset inhibit its ability to monitor and understand the overall effectiveness of services. This compromises opportunities to challenge partner agencies where practice is poor.

The board has developed a multi-agency audit programme that has considered services to disabled children and children at risk of sexual exploitation outside the local authority area. However, the audit programme needs to become further embedded and more sharply focused to provide assurance to the board that the services provided and work undertaken to keep children safe are consistently robust and effective across the county. The inclusion of young people on the board is generally a strength, although the participation of children and families in auditing activity requires development.

The board has a comprehensive range of training events and e-learning courses that have increased the number of practitioners who have received training. The training events include lessons learned from serious case reviews, although the extensive range of messages emerging from this work has diluted the learning. Longitudinal evaluation of the impact of this training requires further development.

Recommendations

111. Strengthen the range of performance information provided to the board to include relevant information from all partners and ensure that evaluative commentary is provided to improve services.

112. Embed the multi-agency audit programme in order for the board to have greater assurance of the quality of frontline safeguarding practice.

113. Strengthen the evaluation of training to ensure that it is robust and can evidence positive impact on outcomes for children and their families.

114. Hold partners to account for evaluating the impact on practice of the learning from serious case reviews.

115. Ensure that the annual report provides a rigorous assessment of the performance and effectiveness of local services.

116. Ensure that the neglect strategy and associated toolkit is promoted across the county and its effectiveness measured to improve outcomes for children.

Inspection findings – the Local Safeguarding Children Board

117. Gloucestershire Local Safeguarding Board (GSCB) meets its statutory duties and undertakes a broad range of work to safeguard children across the county. Governance arrangements between the GSCB and the local authority are well established. The independent chair is proactive and credible. He attends regular alignment meetings with the independent chair of the Gloucestershire Safeguarding Adults Board, the director of children's services and the directors of adult social services. GSCB members express confidence in the independent chair, who is both skilled and knowledgeable in this area of work.

118. The GSCB is also an equal partner of the Gloucestershire children's partnership and the chair is a member of the Health and Wellbeing Board (HWB). The GSCB has strong links with the HWB. These arrangements ensure that safeguarding children is appropriately considered and the planning is aligned. For example, GSCB has ensured that the HWB domestic abuse commissioning strategy fits the board's levels of intervention guidance. The GSCB currently operates eight sub-groups that are appropriately aligned to the GSCB's key statutory responsibilities and priorities. Police, health and children's social care are well represented on the sub-groups and the GSCB executive.

119. Attendance at the board is generally good, although the board is reviewing its current structure to consider how it can progress its objectives most efficiently. There is commitment and engagement from attendees that has

resulted in a greater ownership of safeguarding issues across the partnership. However, the board is not sufficiently informed about the quality of all frontline services and practice. Limited analysis through audits and a lack of qualitative commentary on the board's dataset inhibit its ability to monitor and understand the overall effectiveness of services. This prevents opportunities for challenge to partner agencies when practice is poor.

120. The board has a wide breadth of membership from all statutory partners. The level of seniority is appropriate to facilitate influence and improvement. The private and voluntary sectors are represented, and the board benefits from the active engagement and challenge by three lay members. Their work is a strength, ensuring, for example, that services for children with disabilities are kept in sharp focus. The board benefits from highly effective support and commitment from the business manager and the wider business unit.

121. The GSCB quality assurance framework has included internal review and regional peer challenge. This incorporates a multi-agency audit schedule, serious case reviews and learning from an online pupil survey, as well as learning from the 'ambassadors' for vulnerable children and young people. It does not currently support the board to monitor all safeguarding activity effectively across the county. The board is aware of the limitations of the dataset and is beginning to ensure that the story behind the data is captured, as well as presenting data from a wider variety of sources. (Recommendation)

122. The board demonstrates increasingly open and candid challenge between board members, and this has been effective in some areas, for example in improving awareness of the role of the multi-agency safeguarding hub. Formal challenges are recorded and monitored. Similarly, following emerging concerns regarding the consistency of early-help decision-making and support, the GSCB undertook through the quality assurance sub-group a 'deep dive' audit of early-help services. Although the audit provided assurance that a range of preventative work is happening in the county, it also found that it was not always effective for some families with complex needs. The findings were shared with the children's partnership to inform the development and implementation of the early-help graduated pathway.

123. The voice of the child is an area of strength within the work of the board. Engagement with the 'ambassadors' is innovative and influential, and they have been engaged effectively in contributing to the summary of the annual report, workshops presented during the safeguarding roadshows and the GSCB planning days. Recent developments to formalise their involvement are to be welcomed.

124. Child sexual exploitation arrangements are coordinated and monitored through the child sexual exploitation and 'missing' sub-group, but this does not yet lead to improved practice for this vulnerable group of children. Awareness raising was supported by a successful conference delivered in collaboration with the office of the police and crime commissioner. It is of

note that the rate of referrals has increased significantly as the work of this group has evolved. The role of schools in preventing child sexual exploitation is included in the Gloucestershire child sexual exploitation strategy, and the workforce development sub-group has extended the current training offer from a half a day to a full training day.

125. Robust processes are in place to consider and undertake serious case reviews. Serious case reviews are initiated where necessary and in line with statutory guidance. The board has commissioned six serious case reviews in the recent past, demonstrating innovation in developing a Gloucestershire model for this work. The associated findings and recommendations from reviews have presented some challenge to ensure that the learning is disseminated. Board members agree that issues of capacity have diluted the learning opportunities, and work is currently being undertaken to refine the learning into key themes.

126. The progress of serious case reviews and the completion of subsequent multi-agency recommendations are appropriately monitored and reported to the board. More work is required to ensure that individual agency actions are fully addressed and are improving outcomes for children. Reviews are published and GSCB oversees roadshow events and briefing sessions that are held to disseminate learning. These have proved to be popular and are evaluated as effective. The 'ambassadors' attend and speak at these events and facilitate workshops. However, the impact of learning from serious case reviews is not widely evident. For example, although a number of serious case reviews have found that more work is required to create a culture of interagency challenge, evidence of progress is limited. Despite much work in this area, there has been no significant increase in formal escalations. Frontline practitioners spoken to during this inspection were not always aware of the learning from serious case reviews. (Recommendation)

127. Similarly, the need to improve the professional response to neglect is a key learning outcome from a number of serious case reviews. Having identified the lack of progress in this area, work has been undertaken to develop a neglect strategy and toolkit. The neglect strategy was launched in August 2016 but the toolkit is yet to be disseminated. While the GSCB anticipates that this should result in a more consistent identification of neglect and lead to more effective help at an earlier stage, the guidance is yet to be disseminated. The pace of implementation has been too slow, with the consequence that some children are still left in neglectful circumstances for far too long. (Recommendation).

128. The multi-agency quality assurance sub-group operates an annual cycle of audits that has included in the recent past consideration of services to children with disabilities, children in care and child sexual exploitation. Although the audit reports are completed satisfactorily and lead to recommendations and action plans, a sharper focus is required to assess and inform the monitoring of core child protection activity. (Recommendation)

129. The education sub-group provides good opportunities, through well-attended forums, for raising concerns, disseminating information and sharing good practice between schools and GSCB partners. A safeguarding audit of schools, tailored to address the objectives of the board, achieved an excellent 100% rate of return. The work of this sub-group has also been highly effective in supporting work to raise awareness of child sexual exploitation. It has promoted the delivery of the play, 'Chelsea's choice' to 45,000 secondary school pupils, and a play for younger children, 'In the net', has been successfully piloted and is now shown each year to Year 4 pupils in primary schools across Gloucestershire.

130. The board supports and uses the south west child protection procedures, which have been localised where necessary and made subject to frequent review. The threshold document, known locally as the 'Levels of Intervention' guidance, has been revised to reflect changes to policy and the local delivery structure. The understanding of thresholds for children who require early help but do not meet the threshold for statutory intervention is more recently implemented and is not yet fully embedded.

131. Policies and procedures are accessible through the GSCB website. This is an accessible and informative resource, with links to relevant good-quality information on a range of safeguarding issues. The board is well up on the opportunities to develop communication through social media. The use of electronic alerts and Twitter is increasingly providing opportunities for the board to raise awareness of key issues, for example to promote the more widespread use of the child sexual exploitation screening tool.

132. The GSCB provides an appropriate range of multi-agency safeguarding training that reflects the priorities of the board. Demand for interagency courses is consistently high, and the board is maintaining good attendance figures across all courses. In 2014–15, GSCB ran 147 courses and trained 2,922 delegates. During 2016, 167 courses were held and were attended by 3,402 delegates, representing a significant increase. Training is responsive to changing need, as it captures learning from the GSCB's own audits and serious case reviews for the current training programmes.

133. All training is evaluated, but the low number of feedback responses on individuals' practice three months after their training inhibits evaluation of its effectiveness to deliver safeguarding services. There is a Training Evaluation and Impact Framework in place, which clearly sets out the multi-agency training evaluation process. The chair acknowledges that more work is required in this area in order for the board to be confident about the impact of training in terms of quality of practice and improved outcomes for children. (Recommendation)

134. The child death overview panel (CDOP) is well established, with membership from all key partners, and it carries out its functions effectively. CDOP reports regularly to the board and produces a well-written annual report on trends

and themes in child deaths. A review of all deaths has led to awareness-raising activities, including the production of a leaflet regarding safer sleeping and the dangers of shaking infants. It is notable that Gloucestershire CDOP, through the national CDOP network-learning programme, disseminated learning to reduce the risk of aspiration when tube feeding children at night.

135. The annual report 2015–16, while ambitious, is overly descriptive. Although it covers all appropriate areas, it does not present a rigorous and transparent analysis of safeguarding practice across the county to provide an assessment of the performance and effectiveness of local services. The summary document encapsulates well the key achievements and objectives. Local priorities are reflected in the business plan, with priorities linked to sub-group activities including the commissioning of audits and the planning of training. (Recommendation)

Information about this inspection

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

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

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