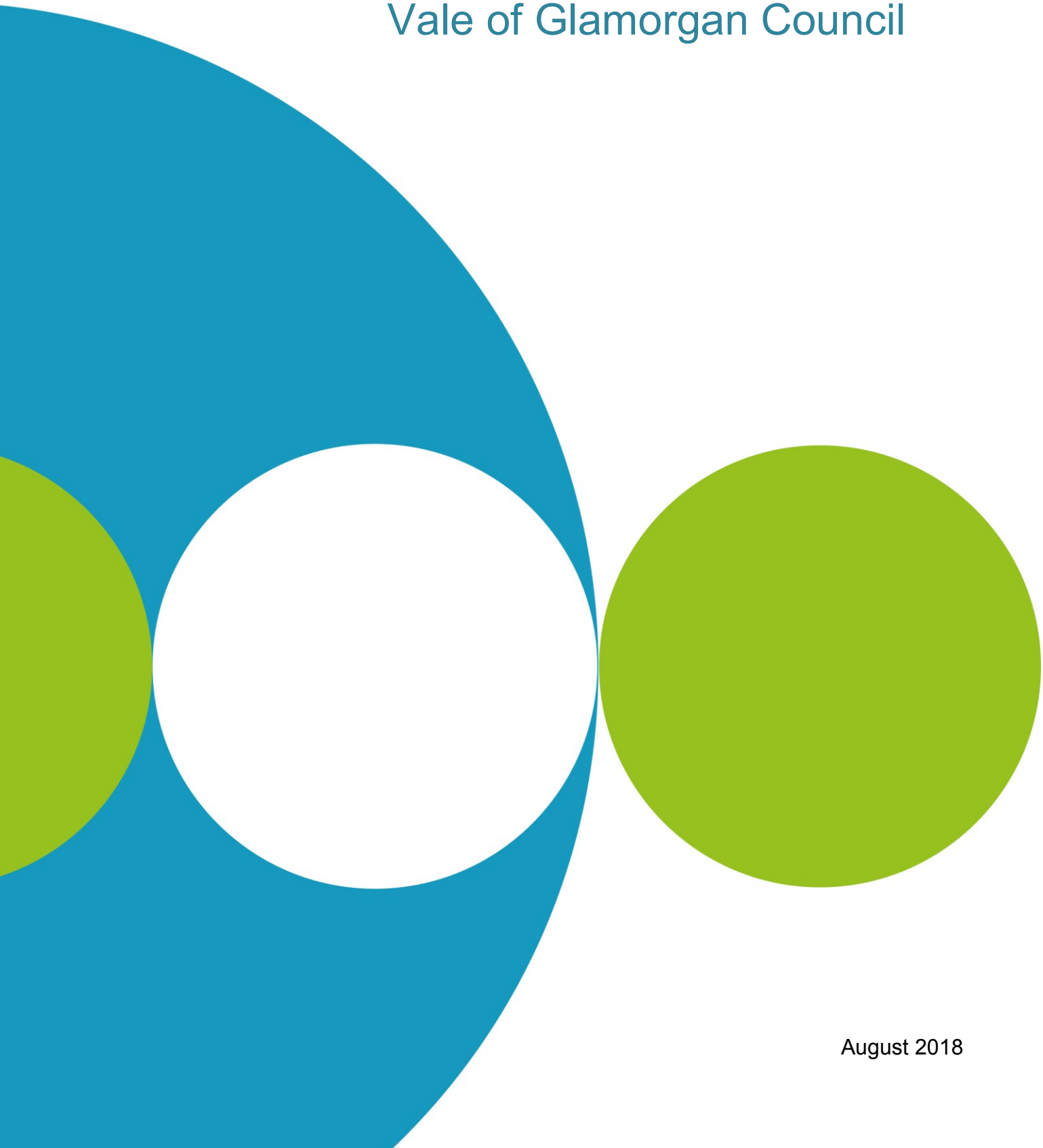
Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Inspection of Children's Services
Vale of Glamorgan Council



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Introduction

Care Inspectorate Wales (CIW) undertook an inspection of services for children in the Vale of Glamorgan Council (VoGC) during May 2018.

Our approach to the inspection was underpinned by the eight well-being statements and associated well-being outcomes as outlined in the Welsh Government's *National Outcomes Framework for People who need Care and Support and for Carers who need Support* (March 2016). Our approach builds upon the associated local authority quality standards set out in the *Code of Practice in Relation to Measuring Social Services Performance issued under section 145 of the Social Services and Well-being (Wales) Act 2014* (SSWBA). In addition, the inspection considered the local authority's capacity to improve through analysis of leadership and governance of social services functions.

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

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

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

- information, advice and assistance (IAA) and preventative services
- assessment /reassessment of needs for care and support and care and support planning
- child protection enquiries, procedures, urgent protective action, care and support protection plans.

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

Overview of findings

- Motivated front line staff report job satisfaction, good provision of training and good management support at all levels including regular supervision

- There is good corporate support for children's services including from elected members. The local authority recognises there is a need to further develop the scrutiny process and members are motivated to do so

- There is a clear commitment to collaborative working across the different departments within the local authority to provide children's services. In other respects, there is room for improvement in the articulation of the high level vision and ambition for children in the Vale of Glamorgan

- The local authority has not implemented a specific model of social work practice within children's services to underpin its key objectives

- The local authority over estimates the extent to which its practice adheres to the ethos of the Social Services and Well-being (Wales) Act. Nearly everyone told us staff were working co productively with families. However, we did not find sufficient evidence of the identification of strengths in our review of case files or in interviews with staff and service users. Care and support plans did not sufficiently detail how personal outcomes would be achieved or allow for evaluation of progress

- Corporate support, motivated staff and the service development work stream place the local authority in a strong position to further develop its service to children and families

- Social work staff knew children's circumstances well and regularly visited. However, vacancies and complex caseloads in the Care Management Team (CMT) have affected the service to children and families. Action was already being taken by senior managers to reconfigure teams to redistribute responsibilities to reduce competing demands on social work time

- Plans did not sufficiently evidence the voice of the child or incorporate risk management. Children looked after were not routinely engaged in their review meetings and Independent Reviewing Officers were not providing sufficient oversight or obtaining the views of children prior to meetings that made decisions about their future

- A robust system of multi-agency panels ensures consistent and effective decision making about placements and permanency planning. Legal services provide good support in decision-making and court proceedings. The recording of the rationale for decision making outside of panels was inconsistent

- Work is ongoing with a neighbouring authority to increase the number of fostering placements as the authority recognises limited choice of placements is contributing to placement breakdowns. It is also working with a provider of residential care in order to place more children closer to home

- Strong partnership working is improving outcomes for young people. This includes good practice in multi agency support provided to care leavers and young homeless people. Care leavers were very positive about the help they receive from Personal Advisors

- In the safeguarding work we reviewed, children were being protected by prompt response and timely assessments. Work is already underway to review quality of protection plans and to improve the active involvement of families in safeguarding processes

- The implementation of the new electronic case management system presents ongoing difficulties for staff and could impact on the availability of information when cases transfer

- Quality assurance arrangements require further development and the authority does not currently have reliable performance management information due to changes in the electronic case management system.

Areas for development

Leadership, management and governance

1. There is a need for further embedding of the principles of the Social Services and Well-being (Wales) Act 2014 (SSWBA) into social work practice.

2. Senior managers are aware of the priority to reproduce a range of performance management information to assist staff and managers to deliver timely and effective services following the implementation of WCCIS.

3. Further work is required to develop a more comprehensive quality assurance system that incorporates specific tasks for managers.

4. Social work practitioners would benefit from a review of the current operationalization of the electronic recording system and from further training to support its use.

5. The local authority should continue the prioritisation of filling vacant posts by recruitment exercises and monitoring reasons for leaving.

Access arrangements: information, advice and assistance

6. A review of referrals where previous contacts or referrals have been received would be beneficial to ensure decision making is appropriately robust.

Assessment

7. Assessments must take into account all available information from previous contacts and incorporate any risks.

8. Practitioners should explicitly seek the views of children seen alone, where appropriate, and fully outline these in assessments.

Care and support and pathway planning

9. The local authority will wish to ensure proportionate recording including rationale for decisions and content of visits to children and the incorporation of risk assessment and management plans into care and support plans.

10. IRO caseloads should be reviewed and IROs should prioritise speaking with children prior to review meetings.

11. The local authority should ensure relevant children are offered advocates and independent visitors.

12. Out of area placement panels should be undertaken in compliance with regulations.

Safeguarding

13. Practice should be developed in co productive working with children and families; considering risks, strengths, barriers and toward agreed outcomes where possible.

14. There should be regular review of safeguarding performance information by the safeguarding unit.

Next steps

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

1. Access arrangements: information, advice and assistance

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

Summary of findings

1.1. We reviewed files looking at how referrals were managed and saw examples of timely and appropriate signposting to preventative services. We also saw examples where several referrals had been received about child/children but where recording was insufficient to evidence all available information and risks had been considered. The authority estimates 90% of contacts are signposted to preventative services or resolved without further involvement. We found partner agencies were sometimes uncertain about thresholds.

1.2. Senior managers have reviewed and added resource at the 'front door' to provide greater support for initial decision-making. At the time of our inspection, this ensured a social work manager reviewed all referrals. The local authority also wished to increase the opportunities for earlier intervention and intends develop this further with the reconfiguration of teams.

1.3. In July to September 2017, 98% of referrals were decided within the statutory timescale. While VoGC has a policy of informing the agency making the referral of the decision, not all agencies could assure us this happened consistently.

1.4. Approaches for information, advice and assistance were made to the duty officer in the Intake and Family Support Team, the Families First Advice Line (FFAL) or the Family Information Service (FIS). There was not a single point of access and each service signposts people to the other as appropriate. The local authority should ensure repeat referrals of the same child are noted and this is taken into account in decision making.

1.5. We found good partnership working with housing and the third sector. For example, there is help with debt management that may prevent evictions and support where domestic violence is a feature. Senior managers are further co coordinating the range of preventative services available to people.

2. Assessment

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

Summary of findings

2.1. The files we viewed evidenced that generally children received timely assessments of their need for care and support. There is room for improvement in identifying the different needs of individual children when assessing a sibling group.

2.2. Some assessments did not include sufficient analysis of all relevant information from previous contacts or risks to come to a robust conclusion and to inform planning to achieve desired outcomes. For the majority of assessments and from the evidence available, there was significant room for improvement in how social workers engaged with the child and family to identify strengths and personal barriers. This is required to comply with SSWBA.

3. Care and support and pathway planning

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

Summary of findings

3.1. We saw many examples of work with families to support children to stay in the home or plan appropriately for children becoming looked after. This included examples of good multi agency work with education, housing, third sector. Social workers visited children regularly, in line with statutory requirements, to ensure their needs were being met.

3.2. We spoke to partners in health, housing and education who were positive about working collaboratively with VoGC children's services and saw a strong ethos of corporate parenting and safeguarding within the authority. Education personnel worked with children's services to ensure Personal Education Plans (PEPs) were accessible and recorded the child's view.

3.3. The local authority commission third sector agencies to provide a range of preventative and early help services to families, including where children are at risk of becoming looked after. Not all practitioners we spoke to were clear what was available and reported a lack of capacity within services. At the time of inspection, the authority was engaged in a re-tendering exercise with the intention of making direct family support and edge of care services services more flexible by having the ability to move staff to respond to fluctuations in demand.

3.4. Currently, children receive initial support from the Intake and Family Support Team. If longer-term involvement is indicated children are transferred to the Care Management Team (CMT), the Child Health and Disability Team (CHAD) and/or the 15+ Team.

3.5. Prior to our inspection, VoGC was aware of the need to reconfigure teams. The composition of caseloads in the CMT reflected too wide a range of work undertaken by this team. A high vacancy rate had built up over the last two years and had reached 50%. Senior managers had brought in agency workers and engaged the workforce in making temporary adjustments to the transfer points between teams as remedial measures. We did not find children without an allocated worker. However, in too many cases we could see the impact of discontinuity for children and families with delays to pieces of work. For example, a delay in a parenting assessment resulted in the child staying longer in foster care before returning to the family home.

3.6. Two thirds of children looked after had more than two changes of social worker in the last six months of 2017. While some children had a change of social worker because responsibility was transferred between teams, this remains a high rate of children with multiple workers in a short time frame. Children we spoke to said they were *annoyed* at needing to develop new relationships when social workers change.

3.7. Addressing this is a significant factor in the planned reconfiguration of teams. The authority has a clear plan to realign the remits of teams to distribute workload more evenly and more effectively meet need, which staff and managers view positively. We anticipate this will be subject to review after a period of implementation to judge success. We were informed greater stability in the allocation of workers had been achieved prior to the inspection.

3.8. The children's disability team was stable and intends to extend services to children with autism and develop an improved multi agency approach to children with complex needs that include disability. The disability team has invested in dedicated workers to ensure children transition well into adult services. We saw good outcomes for children receiving support from this team.

3.9. The Youth Offending Service is part of children's services and has a range of resources for children at risk of offending. Staff and managers described good communication between the different teams in children's services and we saw evidence of this.

3.10. Recording by social work staff was not always sufficiently detailed to demonstrate the quality of support and intervention with children and families. Generally, care and support plans tended to reflect objectives that appeared to have been set by the social worker rather than expressed as personal outcomes reflecting the child's wishes and feelings, as required under the SSWBA. In most instances, from discussion with social workers, we were confident they had spoken with children but plans did not adequately reflect this. The actions were not sufficiently detailed or to a specified timescale and plans were not always updated following significant changes. Progress monitoring, and responding pro actively to change was impeded by plans that were insufficiently specific or current.

3.11. There was inadequate rigour around the assessment of risk in some care and support plans. While we saw completed risk assessments, the child's care and support plan did not always reference this. VoGC is developing a common risk assessment and management tool with other agencies; in doing this senior managers need to ensure risk assessments are better integrated and children and families are fully engaged in identifying and managing risk.

3.12. Although VOGC has a policy that line managers approve care and support plans to ensure quality, this was not routinely occurring in practice. We were not assured that copies of care and support plans are always provided to children and families. In contrast, care plans submitted in court proceedings

are subject to thorough internal review by managers and the authority's solicitors.

3.13. Independent Reviewing Officers (IROs) in VoGC had an average caseload of 114 at the time of our inspection. This is too high for us to be assured IROs were fulfilling their duty of providing oversight of children in the care system and raise concerns about casework. IROs did not routinely meet with children prior to review meetings to ensure they knew their wishes. The written views of children were not always represented well at reviews. Children we spoke to confirmed this and it was not clear what involvement they had in reviewing their care and support plans. This is an area where there is room for significant improvement.

Permanency planning

3.14. There has been an increase in the number of children looked after by VoGC in the last three years. This is part of a national pattern. The local authority holds weekly multi agency panels chaired by a senior manager to review children with regard to permanency planning, complex needs or placements out of the area. The meeting we observed was clearly focused on the needs of the child to avoid drift in planning. Nevertheless, out of area panel meetings were not fully compliant with the Care Planning, Placement and Case Review (Wales) Regulations 2015. While there are nationally recognised difficulties in meeting these requirements, this remains an area for improvement. The purpose of the panel meeting is for VoGC to plan for the child with the statutory services in the area where the child is being placed. The potential impact of not doing so is a deficit in the multi agency planning to support a child placed out of the area.

3.15. VoGC has a clear structure for decision making around initiating the Public Law Outline (PLO) and court proceedings. The legal gateway meeting is robust and well minuted. The authority's team of solicitors is sufficient and well regarded and provides legal scrutiny and support to complex court work. Most children looked after were previously subject to child protection registration and had been provided with support in the community. Previous social work involvement and the thoroughness of the complex needs panel and legal gateway meetings provides assurance that decisions to initiate care proceedings are appropriate.

Placement choice, stability and wellbeing

3.16. As in other local authorities, the numbers of children looked after placed with parents and connected persons has more than doubled in the last five years. The children we spoke to who were looked after did not remember being given any choice about where they were placed. The shortage of suitable residential or foster placements for children with complex needs is a major challenge to VoGC. This is an acknowledged national issue but the local authority retains a duty to provide sufficient placements. The use of 'bridging placements', while the authority waits for a longer term placement to be available, adds to the

number of placement changes for children. This brings further instability to children's lives and exacerbates difficulties in attachment and forming relationships.

3.17. The number of children VoGC was looking after in residential care at the time of the inspection had halved over the last three years. The local authority has worked to care for children in foster placements where possible. VoGC has a service level agreement with the provider of two local children's homes but has not fully utilised this arrangement due to the complexity of need of the children requiring placements. There is current work to improve those services with the intention of VoGC placing more children in residential care closer to home.

3.18. VoGC has not increased the numbers of its mainstream foster carers in line with demand in the last few years. A separate inspection of the fostering service was undertaken at the same time as this inspection and the report is available. The authority was responding to the shortage of foster carers by working with a neighbouring local authority on a joint approach to recruit more carers. Senior managers recognise the rate of breakdown of placements within its fostering service has increased due to reduced choice when matching a child with foster carers. Breakdowns will have added to the distress and disruption that brought these children into the care system.

3.19. Many children who become looked after require specific therapeutic input to help address emotional trauma. VoGC commissions relevant services and we viewed files where children were receiving effective therapy. Social workers told us of the need for increased availability of therapeutic support and the local authority is extending the psychological resources already in place, which have been working directly with children and providing advice to staff and foster carers. Limited additional resource was also accessed from Child and Adolescent Mental Health Services (CAMHS).

Care leavers and young homeless people

3.20. Many of the files we viewed demonstrated young people leaving care receive a high degree of support from Young People Advisors (YPAs) who know them well. Care leavers we spoke to were extremely positive about the emotional and practical support they received.

3.21. As in other areas of Wales, there is a paucity of therapeutic support for young people in this age group who are dealing with the impact of Adverse Childhood Experiences (ACEs).

3.22. The quality of pathway plans was an area for improvement. Risks to young people were not always adequately included in plans and the wishes and views of young people were not always sufficiently evident.

3.23. VoGC has formed some excellent working relationships with housing and third sector providers to develop a range of accommodation options for young people leaving care or who are aged 16-21 without a home. The authority

funds support for young people to develop independent living skills and maintain tenancies. This reduces the likelihood of eviction and the spiral of homelessness that has such a negative impact on well-being. Arrangements between departments in the authority and with partners have created opportunities for young people to receive sponsorships, apprenticeships and other employment options.

Participation

3.24. There were 238 review meetings held for children looked after from January to May 2018 and one third of children attended their meeting. This figure includes very young children who we would not expect to attend and some children will always choose not to attend. However, given the importance of engaging children in planning, VoGC may wish to consider what changes it can make for reviews to be more inclusive and 'child friendly'. Some children we spoke to did not recall being invited to reviews and did not feel encouraged to attend. IROs have a significant role here and we cannot be confident how the child's views are communicated, particularly if the IRO is unlikely to have spoken with the child directly beforehand. One child objected to meetings being held at their school because they did not want to miss lessons and wanted school to be a place where they could be the same as other children.

3.25. VoGC regionally commissions advocacy services for children who are looked after, are named on the child protection register or in receipt of care and support. Most of the children we spoke to confirmed they had been offered an advocate. There was a drop in referrals to the advocacy service in 2017/18 from those social work teams most affected by vacancies. VoGC is not currently facilitating any children looked after to have an independent visitor[1].

[1] A lay volunteer spends time with the child and offer support and friendship to help maintain links with the child's home community.

4. Safeguarding

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

Summary of findings

4.1. We saw examples of safeguarding practice where the response was prompt and good multi agency working resulted in the swift protection of children. We did not identify any unsafe practice. However, we also saw examples where there was a lack of recording on whether the child was seen alone and where there was insufficient detail to evidence all concerns had been fully considered. The assessment reports for child protection conferences we viewed were thorough, with clear analysis of risk.

4.2. There were national and local guidance and protocols in place for multi agency responses to children at risk of child sexual exploitation (CSE), those displaying harmful sexual behaviour and who go missing. The police viewed joint working with VoGC as good and have a consistent point of contact with regular meetings to review individual children at risk of CSE and the disruption of perpetrators.

4.3. We saw examples of young people at risk of CSE who may have benefitted from specialist direct work. The local authority's threshold for commissioning services was not clear to the social workers we spoke to. VOGC may want to consider if social workers/ social care officers have sufficient skills and capacity to deliver direct work to this group of young people and confirm the criteria for use of a specialist agency.

4.4. The local authority was in the process of reviewing its safeguarding practice to ensure plans to protect children are of consistent high quality and actively involve the family. Senior managers in the safeguarding unit did not review performance data on the safeguarding process, which would allow them to evaluate timeliness and identify areas for improvement. This was acknowledged as an area for improvement.

5. Leadership, management and governance

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

Summary of findings

5.1. Children's Services has strong corporate support and cross party support of members. There was an understanding, for example, that high cost placements for young people are sometimes required. The pooled funding arrangement between education and social services aids the placement process once decisions are made. The Managing Director articulates strong aspirations for children in VoGC and has a focus on safeguarding and corporate parenting responsibilities across the directorates.

5.2. Key objectives for Children's Services are outlined in the Corporate Strategy and everyone we spoke to was clear their focus was on the needs of children. The Corporate Strategy does not provide a high level vision that evidences the ambition of the local authority for children and families.

5.3. The local authority has not implemented a specific model of social work that underpins the work of Children's Services. This is not a requirement and previously the authority has not been convinced of the merits. Current service development work will involve reconsideration if there would be benefit in doing so.

5.4. There was a gap of 14 months in the activity of the Corporate Parenting Board attributed to the change of members after the 2017 election and consequent training needs. Although we have not identified specific impact of this, senior personnel we spoke to acknowledged the extensive delay was unfortunate. Turnover in the membership of the social care scrutiny committee means there is room for further development in its function to challenge and hold Children's Services to account. There had been no engagement with front line staff or with children to hear their experiences. Members we spoke to were clearly committed and we anticipate they will grow in knowledge and experience.

5.5. VoGC seeks the views of children and families by a variety of means and maintains an annual programme of consultation. The SSWBA introduced a duty on local authorities and health boards to undertake an assessment of the care and support needs of the population (Population Needs Assessment).

VoGC worked with Cardiff Council, Cardiff and Vale University Health Board and other partners and has recently published the area plan and associated action plan for 2018-23. The latter sets the work plan of the Regional Partnership Board and the priority areas that pertain to children are: children with complex needs, integrated family support services and young carers. It is too early for us to evaluate progress in delivering the area plan.

5.6. Generally, staff were very positive about the support they received to perform their duties and develop professionally. A good range of training was available, including direct work with children. Staff view managers at all levels as helpful and accessible. Children's services staff reported increased job satisfaction in the VoGC 2017 staff survey and felt trusted to 'get on with the job'. These were very positive results given the significant pressures in some teams of large and complex caseloads and staff vacancy levels.

5.7. CIW last inspected VoGC Children's Services in 2014. The authority has largely addressed the areas for improvement identified at that inspection. A recommendation that staff have more time to complete direct work with children looked after has remained an issue but it is acknowledged the planned reconfiguration is intended to address this.

5.8. Staff received regular monthly supervision discussing caseloads. VoGC is compliant with its policy of adding supervision notes to children's files. Staff we spoke to were happy with the supervision they received. However, we found little evidence of reflective practice in the recording of discussions, whereby effectiveness of approaches are explored and alternatives are considered. There was also less evidence of decision making in supervision notes than we would expect to see although decisions may be more likely to be made in the system of panels. An audit of supervision records for 2017/18 did not demonstrate routine management review of supervision records in Children's Services.

5.9. We found significant room for improvement in quality assurance arrangements. This has been recognised by the authority who were about to implement a new framework. However, we believe this should be more extensive to ensure consistent high standards of practice. IROs were not adequately able to fulfil their quality assurance function due to high caseloads. Recent case audits conducted by the authority were too small in scope to be representative and routine 'dip sampling' by managers at all levels is not occurring. Line managers were not signing off care and support plans. Safeguarding practice was not being reviewed in regular performance management information.

5.10. VoGC transferred to the WCCIS case management system in November 2017. One of the impacts has been an inability to produce a comprehensive suite of performance indicators since this time. This is a priority and is likely to be available in the next few months. This has left managers without an electronic means of monitoring service delivery and have had to rely on manual extraction of data.

5.11. The implementation of WCCIS remains problematic for many staff we spoke to and who said they would benefit from further training. VoGC has retained a secondary document management system, but some staff voiced concerns about missing significant information about a child. This is particularly important where newly allocated social workers need to readily to access all information.

5.12. The local authority acknowledged the significant recruitment difficulties within children's services, particularly within the CMT. The reconfiguration of teams is intended to spread vacancies and reduce impact. Senior managers attributed the problem to several issues and therefore viewed retention as not easy to resolve. Vacancies and the use of agency workers has impacted on the continuity of service to children and families. We found the complexity of caseloads in the CMT limited opportunities for reflection and provide direct work to children and families. Social care staff told us their individual commitment drove them to work 'above and beyond'.

5.13. VoGC was compliant with Welsh Government guidance on handling social services complaints. It had good management system of oversight of timescales in investigations and findings. Some parents we spoke to were not aware of the complaints procedure. Senior managers routinely meet complainants to try resolving matters and most choose not to request further escalation of the complaints process. The local authority may wish to conduct a review to assure itself this approach is to the satisfaction of complainants.

Methodology

Self-assessment

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

Fieldwork

We selected case files for tracking and review from a sample of cases. In total we reviewed 46 case files and we followed up on 12 of these with interviews with social workers and family members. With four case files, we met with a group of professionals working with that family. We interviewed children, parents and relatives.

We interviewed a range of local authority employees, members, senior officers, director of social services and the managing director. We reviewed six staff supervision files and 18 records of supervision. We looked at a sample of three complaints about children's services.

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

Inspection team

Lead Inspector: Denise Moultrie. Supporting Inspectors: Bobbie Jones, Mike Holding, Pam Clutton, Tracey Shepherd and Sara Hubbard.

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