Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Inspection of Children's Services
Powys County Council

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Introduction

Care Inspectorate Wales (CIW) undertook an inspection of services for children in Powys County Council (PCC) during October 2018. This inspection followed up on a previous inspection in July 2017 which identified serious concerns about the delivery of children's services in PCC which were leading to poor outcomes for children and their families.

Our approach was underpinned by the Social Services and Well-being (Wales) Act 2014 (SSWBA) and associated well-being outcomes outlined in Welsh Government's National Outcomes Framework for People who need Care and Support and for Carers who need Support (March 2016).

This follow up inspection considered evidence of improvements made, and PCC's capacity to continue to improve through analysis of leadership and governance of social services functions. The inspection reviewed early help services for children and families, quality and timeliness of assessments and the provision of care and support services. Throughout the inspection we focussed on the experience of and outcomes for children receiving support within their families or as children looked after by the local authority. Inspectors read case files, and where possible, spoke to children and their parents. We interviewed staff, managers and professionals from partner agencies.

Overview of findings

We acknowledge the hard work of all those involved with Powys County Council children's services to drive, support and deliver improved services. This report outlines the developments and improvements we found at inspection and makes reference to the local authority's plans which, if effective, should deliver further improvements to services for children and their families living in Powys. The local authority must develop a clear strategic direction and effectively translate this into a coherent operational framework for delivering services which is understood and owned by the workforce and key partners. Specifically, we found there was no common understanding amongst staff or partner agencies about the approach being taken by the local authority to develop services, including preventive services. The continued turnover in the workforce and temporary middle management arrangements have been significant factors impacting the pace of change.

We consider PCC children's services has achieved significant improvements in certain areas of practice and some improvement in other aspects. There continue to be other areas of practice where we have serious concerns.

Improvements since last inspection

- Greater corporate oversight of children's services, including indications of improving challenge and influence via the scrutiny process.
- Renewed participation by senior managers in the regional safeguarding board and reactivation of the local safeguarding operational group and corporate parenting group.
- Development of a quality assurance framework and resources allocated to this function with a suite of performance information now available to aid management oversight and the improvement agenda.
- New and revised policies and practice guidance developed in several areas should provide greater clarity for social workers and partners.
- Greater ease of access to the 'front door' of children's services and greater timeliness and quality of initial decision making through strengthened management oversight.
- Co-location of the Team Around the Family (TAF) with Powys People Direct (PPD) offers the opportunity for immediate signposting to early help services.
- Assessment teams have been established and there are some indications of improving timeliness and quality of assessments.
- Improvement in timeliness and quality of applications for court orders in respect of children.
- Significant improvements in regularity of visits to children looked after and subject to child protection registration.
- Reduction in individual workloads and significantly increased regularity of staff supervision.

Areas for development

The report identifies many areas for continued development; we find the priority areas for action are:

- Ensure there is a clear strategic vision to direct overarching planning and the delivery of a seamless service for children and families, incorporating effective early help and family support services alongside statutory intervention.
- Clearer focus on improving strategic relationships with partners to increase collaborative working to the benefit of children and families.
- Development of a commissioning strategy and social work practice to anticipate children's accommodation needs, reduce the numbers of emergency placements and enable PCC to better fulfil its duty to access a sufficient range of accommodation for looked after children close to home. To minimise the number of children placed without agreed educational provision.
- Ensure the safeguarding process incorporates multi-agency information sharing as soon as possible following referral to ensure informed practice and best

outcomes for children. Ensure an immediate multi-agency response to safeguard children at risk of sexual exploitation (CSE).
- Ensure investigations of complaints are thorough and timely in accordance with Welsh Government guidelines.

Existing local authority plans to restructure children's services, implement the signs of safety approach and establish a cohesive strategy around early help and family support could impact positively on several of the areas outlined above.

Next steps

CIW expects PCC to review their existing improvement plan in response to the areas for development contained in this report within 20 working days of publication. Due to the areas of serious concern identified in this inspection, CIW will continue to actively monitor the quality of services delivered by completing focussed activity on a quarterly basis. We will consider undertaking a further inspection of children's services 12-18 months from the publication of this report.

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 Management of PPD had been strengthened. This is the 'front door' to early help and statutory social services. Previous issues of capacity and accessibility have improved and resulted in more timely and informed decision making on initial contacts from families asking for help or professionals raising concerns.

1.2 A regional threshold document had been introduced since our last inspection and was well received in children's services. Further development is required for the understanding of thresholds to be shared across referring agencies. While some agencies took the view concerns raised with children's services were not always sufficiently responded to, PPD staff believed they were sometimes asked to intervene with families unnecessarily. This remains an area for further development, to ensure efficient use of resources and appropriate response to risk and need.

1.3 Since our last inspection the Team Around the Family (TAF) had moved to be co located with PPD. This had begun to improve immediate signposting and increased referrals to the service. However, the number of families being referred remained below what senior managers anticipated and thresholds between the services required further attention. We continued to find insufficient operational support for this service; for example social services did not always attend TAF panels. We noted a lack of confidence, communication and professional understanding between frontline social work staff and colleagues in the third sector, exacerbated by turnover in children's services staff.

1.4 We are aware of a strategy to develop an improved and more coherent range of support services for families; including early help, edge of care, Integrated Disability Service (IDS), and Integrated Family Support Team (IFST). This has not yet been implemented but could provide significantly improved support to families if it is suitably resourced and supported by robust multi-agency collaboration.

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 More assessments were completed within 42 days than at the time of the last inspection, which is an improvement. It is proportionate to complete some assessments more quickly but improvements earlier in the year in completing assessments in a shorter timescale had not been sustained. Senior managers should ensure assessments are completed as quickly as is appropriate to the complexity of need so children are not waiting unnecessarily for the completion of an assessment.

2.2 Approximately one third of social work assessments we reviewed included good information gathering and strong analysis and some demonstrated a thorough approval process by the line manager. This is a significant area of improvement and may be due to the formation of dedicated assessment teams. Clear points of transfer were established.

2.3 However, improvements were not consistently evident. Some assessments did not sufficiently attend to the child's previous history, levels of risk and need for swift action. We saw examples of insufficient consideration of the impact on the child of exposure to domestic violence or other parental behaviour. Opportunities to use the assessment to enable the family to reflect on how they might do things differently were often missed. Assessments of siblings together sometimes neglected the individual needs of one child, while highlighting another. Lack of robust analysis of presenting information meant that some children were left vulnerable or unlikely to receive the support they most needed.

2.4 In many instances, assessment documents did not evidence the wishes and feelings of the child, an issue raised at the last inspection. On occasion, booklets were left with a child asking them to write down ‘what matters’, with no direct engagement by the social worker. Recording and analysis of strengths and needs of individual children and families, and therefore in the identification of care and support required, was inconsistent. There was evidence children were not always subject to a reassessment when their circumstances changed to ensure the care and support provided continued to be the most suitable.

2.5 Overall, the quality of assessments seen remained too inconsistent and further improvement is required. Management oversight must equally focus on quality as well as timeliness of assessments.

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 Fewer children were subject to care and support plans than at the time of the last inspection. Although we did see some very good plans which evidenced intervention in line with SSWBA, overall we did not note improvement in care and support plans since the last inspection. PCC completed its own audit of files, which concurred with our findings. In a small number of cases, inspectors sought further clarification and assurance from senior managers during the inspection that issues they identified had been addressed.

3.2 We found plans often did not identify the outcomes the child and parents wished to achieve, nor their wishes and feelings and existing strengths within the family. Staff training on outcomes has not sufficiently impacted on practice. Plans were often generic and task driven with little evidence of direct work that might facilitate change in underlying emotional and behavioural issues and thereby improve outcomes for children. Plans did not routinely outline timescales for actions or success criteria.

3.3 Plans did not routinely reflect the findings of the assessment. This was particularly significant given the turnover in social workers. Plans did not always support new workers to readily understand the needs and risks within the family. We saw examples of difficulties experienced by social workers when allocated children in complex family circumstances, often following multiple changes of worker and team manager and subject to previous drift and delay. The electronic case management system also did not help social workers gain an overview of events and chronologies were often not up to date. The recent introduction of practice guidance on maintaining chronologies is a positive development.

3.4 We noted files where there was a lack of recorded decision making; vital for children who want to understand their history later in life and for informed professional practice. Minutes of legal planning meetings were rarely held on children's files and there was a lack of clarity as to where records were stored.

3.5 Wellbeing officers (WBOs) completed some good quality direct work with families, but there were limited family support services social workers could draw on. 'Step down' and edge of care services were under developed and underused. There was a lack of confidence by social work staff that services would be effective. Concerns about capacity and possible delays reduced interagency trust and overall services were not clearly understood.

3.6 The plan for enhanced commissioned support services, outlined in the Access section of this report, should benefit issues highlighted. We also identified a need for greater awareness of, and access to, specialist assessment and therapeutic services. A panel established to facilitate access to resources did not seem to have this information available systematically.

3.7 More children were looked after by PCC than at the time of the last inspection. The senior judiciary regards the quality of local authority applications to the family courts as improved over the last 18 months. However, there were concerns about missed opportunities for earlier intervention and the number of urgent hearings. We saw examples of this in the course of our inspection including delays between decisions to apply for a care order and action being taken.

3.8 Children looked after were much more likely to receive regular and timely visits from their social worker than at the time of the last inspection. There has been considerable focus by managers on this aspect of performance and significant improvements had been achieved. Children had often experienced a number of changes of social worker which inhibited the maintenance of meaningful relationships.

3.9 PCC had recently increased its resource of Independent Reviewing Officers (IROs) and was developing performance data for review and core group meetings: this was not yet available. IROs did seek to see children prior to review, although this was often immediately before the meeting. Overall, the IRO function to provide challenge and prevent drift was underdeveloped despite a refresh of the policy of escalation of IRO concerns within PCC. Senior managers should ensure staff and managers fully understand the function of the IRO. We also found the IRO resource to be under developed in terms of the contribution officers could make to quality assurance and corporate parenting. IROs complete individual monitoring forms but did not know if these were collated and analysed to identify themes for learning.

3.10 Young care leavers we spoke to valued their personal advisors (PAs) and appreciated the advice and practical support they provided. They felt more could be done to make young people aware of their entitlements and provide access to therapy. The local authority had recently appointed team coordinators to

reestablish a dedicated team for care leavers/16+, noted as a deficit at our last inspection. PAs felt professionally isolated in generic childcare teams, without access to line management expertise. Senior managers accepted they had continued to 'lose sight' of care leavers, strategically and operationally, since the time of the last inspection. There was a plan to trace eligible young people and repeat the offer of support but this had not yet been enacted.

Commissioning and placement finding

3.11 Considerable work is required to develop and enact a coherent strategic commissioning framework and placement finding process. Very little identifiable progress in achieving this was evidenced during this inspection although the director had identified this as a priority area and had begun the process of combining the children's commissioning team with the adult commissioning team.

3.12 A third of children looked after were placed out of the local authority area; although we acknowledge due to the size of Powys, a child may be closer to home in a neighbouring authority than if placed at the other end of the county. We also acknowledge there is a national shortage of residential placements. However, we found senior managers had not yet acted to make greater use of the 13 children's homes in Powys run by private providers which are rarely used for Powys children or to commission the development of placements to meet specific needs.

3.13 The local authority was mindful of the number of children who have experienced three or more placement moves within 12 months, which has increased in recent years. Senior managers were aware they need to develop a more robust process of matching children to long term foster placements. Placements had broken down where it could have been anticipated carers could not meet children's needs. This had led to carers resigning. There was recognition that PCC does not sufficiently support its foster carers.

3.14 There were indications placement finding had become less systematic and robust over the past year. The specialised task of placement finding and contract monitoring was under resourced. Social workers had to spend considerable periods of time searching for placements, which was not their role. We were informed there had been very few approaches to the national commissioning framework partnership by PCC in previous months. This meant more children were placed in residential placements without the benefit of the quality assurance provided by the commissioning framework. We were not confident there was a formal process for PCC to assure itself of the quality of placements once a child was placed. We were informed of very recent action which had been taken to

review these practices and ensure more effective managerial oversight of this system.

3.15 Some children were placed in an emergency which may not have been required if additional supports had been provided to parents or existing carers. More effective earlier intervention in some instances would have prevented later crises where PCC was left with little alternative than to place the child, or move her/him from one placement to another.

3.16 Some children had been placed without a plan for the placement and with very little information for carers about the young person and their needs. Senior managers accepted emergency placements were often made without any provision for children's education. We saw examples of children without education for several months. This practice and decision making will have increased the likelihood of placement failure with the consequent impact on the child's wellbeing, educational attainment and long term outcomes.

3.17 A newly established access to resource panel had a wide brief which overlapped the function of the multi-agency placement panel (MAAP). Improvements are required in the clarity of decision making to ensure this is based on identified individual needs, using specialist assessments where appropriate.

3.18 The local authority identified an ongoing challenge to achieve timely and accurate recording practice. Some problems with the electronic case management system are national issues. We were informed of other ICT problems that resulted in lost recording and other inefficiencies which were being addressed.

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 Initial strategy discussions are now held by PPD staff and police and this has aided speed of initial decision making. There were continued issues with police and team manager availability where children were already in receipt of care and support that led to delay in holding strategy discussions, due to a different process being followed.

4.2 We reviewed a sample of case files and our findings were mixed, in line with PCC's own audit. We saw examples of thorough safeguarding assessments and timely and effective action to protect children. Equally, we saw drift and delay, often as the result of turnover of social workers and team managers. Some children were left vulnerable for longer than they should have been. Parents and children told us of having to re tell their story to new social workers and they often got the impression the social worker did not know the detail of concerns and past events. This made them anxious that matters would be missed and we found some evidence of this.

4.3 We saw examples of good multi-agency working, including the involvement of the Child and Adolescent Mental Health Service (CAMHS). Equally, we saw prolonged delay where specialist assessments could not be readily obtained and a lack of creative thinking about alternatives.

4.4 PCC continued to convene relatively few multi-agency strategy meetings compared to other Welsh local authorities. We raised this previously with senior managers but practice had not significantly changed. Representatives from the health board had worked with PCC to become more involved in the early stages of the safeguarding process, but this required revision to ensure health board staff were available within the timescales necessary for safeguarding

procedures. We continue to be concerned at the lack of information sharing between agencies to inform assessments and decision making prior to child protection case conferences.

4.5 Senior managers noted high numbers of safeguarding assessments did not find the need for further involvement of the safeguarding system. Unnecessary assessments will have impacted on families and resources. Conversely, decisions based on incomplete information are potentially unsafe. Partner agencies continued to express concerns about PCC practice during this inspection.

4.6 The number of children subject to child protection registration fluctuated over the past 12 months. PCC has achieved significant improvement with respect to the frequency and regularity of visits by social workers to children on the child protection register since the last inspection. We were informed of issues that resulted in cancellation of child protection conferences at short notice. IROs were not confident families were always seeing social work reports in advance of conferences and concurred with our view that child protection care and support plans were often insufficiently specific about what was required of parents and the outcome/ change to be achieved.

4.7 We continue to be concerned at PCC's response to children at risk of child sexual exploitation (CSE). The local authority is not operating within its agreed pathway for managing risk[1]. Multi-agency strategy meetings were held monthly rather than within eight days. This is inadequate to enact safety plans, decide upon safeguarding assessments and the potential for criminal investigations. Bi monthly multi-agency child sexual exploitation meetings (MACSE) were not conducted in line with regional terms of reference and were contributing to delay in the safeguarding of young people at risk of CSE. We have previously raised these matters with senior managers and we are concerned changes had not been made prior to the inspection. We welcome the information that PCC will recruit a dedicated officer to lead improvements in this area of practice.

4.8 Senior managers had become actively engaged in the regional safeguarding board and its subgroups and were providing required performance information. These are improvements since the last inspection. Senior managers in PCC and other agencies had ensured the local multi-agency safeguarding group was also significantly more effective than previously and afforded ongoing opportunities to improve safeguarding practice and understanding across agencies.

[1] *Powys Local Operational Group Pathway for Child Sexual Exploitation*

5. Leadership and governance

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

Summary of findings

5.1 We found significantly increased corporate oversight of children's services. The shared awareness of the transformational change required in children's services to meet its statutory duties and deliver a quality service to children and families will clearly need to be sustained over the longer term and in the face of significant financial challenge. The independently chaired Improvement and Assurance Board was a substantial resource for the Leader of the Council. Inter directorate and inter agency collaboration will be vital to future success.

5.2 PCC restructured its scrutiny committees in May 2018 to improve clarity and focus and members received external support and training. A recent Wales Audit Office report found the scrutiny function had been slow to develop and suggested a review of links between scrutiny and cabinet to increase effectiveness of the scrutiny function within the council.[2]

5.3 A permanent director of social services took up post in May 2018 and a permanent head of children's services in October 2018. Both individuals are new to their roles and will benefit from ongoing support. The interim chief executive will be replaced by a permanent appointment in early 2019. Clearly these posts are key to further improvement and the development of an overall and coherent vision for children's services, beyond the improvement plan.

5.4 We saw examples of good partnership working at individual case level. We noted efforts by an education officer to raise awareness of social services thresholds in schools and facilitate improved professional working. However, there was consensus that partnership working remained under developed at strategic level

[2] *Overview and Scrutiny. Fit for the Future?* September 2018

and the director expressed a commitment to achieve improvement at pace. Housing representatives believed ground had been lost in respect of collaborative working but there had been recent indications of progress. The third sector did not feel like equal partners with the local authority and there was room for improvement in strategic work with health.

5.5 The Start Well initiative is a substantial collaborative project which should bring future benefits to early help services in the local authority. The Regional Partnership Board has specific responsibilities to promote and drive collaborative working and consider barriers and should be an effective mechanism to facilitate and contribute to improvement in children's services.

5.6 PCC has developed extensive performance information for children's services and this is a significant improvement since the last inspection. Managers could be assured of service delivery and identify areas for improvement on an individual and team basis. There was some evidence managers were more confident in addressing poor individual practice. Senior managers recently identified some problems with data accuracy which were subject to review. PCC has appointed a dedicated policy officer who was revising policies and good practice examples and making these more accessible to staff.

5.7 Senior managers had engaged with colleagues in other local authorities, to an extent. Utilisation of external support and resources to maximise knowledge and understanding from the experience of others is an area for further development at officer and member level.

5.8 We noted the re-establishment of the corporate parenting group and the extension of membership to be cross party. Training had been provided for members to promote greater effectiveness. The chair identified further improvement is required to ensure consistent attendance by all statutory agencies and to create a voice for children by ensuring representation of young people.

5.9 Children's services remains dependent on a sizeable number of agency staff at social worker and team manager level. The workforce was over its establishment which allowed reduction in the average individual workload during 2018. Based on local authority data, workloads in PCC were in alignment with other Welsh authorities, although there was variance across teams. Although there was a slowing in the number of staff leaving children's services, the workforce was still considered *fragile* by senior managers. A small number of staff with competency or conduct issues had been identified and support and challenge overseen by senior managers. The director intends to reduce the numbers of temporary additional staff over a period of time.

5.10 A restructure of children's services was about to go to the workforce for consultation. The plan at the time of the inspection was to create teams with fewer defined functions, to allow workers to focus on one area of work and reduce workload inequalities. The director believes the restructure will significantly aid recruitment. The restructure will also allow the director to introduce permanent management arrangements and this should provide further assurance to staff.

5.11 Since the last inspection, senior managers had identified a social work model that is being introduced as a shared approach across children's services. The signs of safety approach is an established model and PCC has invested in training staff and managers. It advocates a collaborative approach in working with families, building on their existing strengths. If operated consistently, and with ongoing quality assurance and management oversight, it could address some areas of practice identified for development in this inspection.

5.12 PCC has significantly improved the regularity of staff supervision since the last inspection. Its own audit found supervision discussions overly task centred. We found some improvements in the detail of case discussions, although this was mixed across our small sample.

5.13 Responses from frontline staff demonstrated an improvement in morale since our last inspection. Staff described a strong sense of peer support and teamwork. The majority felt supported by line managers and senior managers, although a minority spoke of senior managers not being as visible as they would wish. The majority stated they had a manageable workload. Responses are likely to have varied across teams impacted differentially by staff and manager vacancies.

5.14 While team managers felt well informed, frontline staff generally did not feel sufficiently aware of service developments. Staff described improved access to training opportunities and were appreciative of revised policies and procedures. Staff we spoke to and who responded to our online survey were majorly supportive of the proposed re structure and the introduction of the signs of safety model.

5.15 A quality assurance framework has been developed since the last inspection and resources allocated to support implementation. Case file audits were thorough, although the culture of managers regularly auditing as part of their role was not yet fully embedded. As identified above, IROs could contribute more to quality assurance. PCC will wish to ensure responsibility for quality assurance is accepted across the workforce and is structurally linked with organisational learning to maximise impact.

5.16 People making complaints about children's services were not receiving timely, quality responses in line with Welsh Government guidance and there were indicators of deterioration since the last inspection. Attempts to resolve issues locally were subject to considerable delay and were of variable quality. A high number of complaints had been escalated to the second stage of the process. These were also not concluded within timescales and many were open for several months and some over 12 months. The major issue giving rise to complaints was delay or lack of communication from staff and managers. Delayed responses by those investigating complaints will have exacerbated the negative experience of complainants. Learning from complaints was unsystematic and poorly developed. Senior managers will wish to review this process as a matter of priority.

5.17 There was evidence that relevant young people were being offered advocacy and the commissioned agency was endeavouring to further raise professional awareness of the 'active offer' to young people. PCC was aware of considerable further work to ensure children and families participate in decisions around service developments and have their voices heard.

Methodology

We selected case files for tracking and review from a sample of cases.

In total we reviewed 48 case files and followed up on 16 of these with interviews with social workers and family members.

With four case files, we met with a group of professionals working with the family. We interviewed a range of local authority employees, elected members, senior officers, director of social services, the interim chief executive and other relevant professionals.

We administered a survey of frontline social care staff and received 84 responses. We reviewed six staff supervision files and 18 records of supervision. We looked at a sample of three complaints and related information.

We reviewed performance information and a range of relevant local authority documentation.

We interviewed a range of statutory organisations and partner agencies from the third sector.

Inspection Team

Lead Inspector: Denise Moultrie. Supporting Inspectors: Mike Holding, Katy Young and Tracey Shepherd.

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