Cheshire West and Chester

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: 24 November 2015 – 17 December 2015

Report published: 19 February 2016

Children's services in Cheshire West and Chester are good		
1. Children who need help and protection		Good
2. Children looked after and achieving permanence		Good
	2.1 Adoption performance	Outstanding
	2.2 Experiences and progress of care leavers	Good
3. Leadership, management and governance		Outstanding

[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

Children's services in Cheshire West and Chester are good. The director of children's services and the senior management team have worked hard to successfully communicate their clear vision of high standards of practice. Social workers have stayed with the authority, raising their standards and contributing to the improvements. This outstanding leadership has resulted in good-quality services that respond to the needs of children and families quickly and effectively.

Significant work by both leaders and staff has reinvigorated partnerships with other agencies to develop and implement a shared approach to the assessment of risk and the understanding of thresholds. As a result, key strategic priorities such as children who go missing or who are at risk of sexual exploitation are clearly focused on children and families who benefit from effective multi-agency working. The director of children's services is a calm and purposeful leader who understands his services very well. He has a direct line of sight to front-line practice that enables him to have a sufficiently clear understanding of any performance issues that arise. In turn, leaders and managers respond quickly to rectify them. Social workers are well supported and supervised by their managers, who have regular oversight of casework. Leaders and managers understand local need – they respond to changing demands and have planned well for the future. This is reflected in the strategic service plan and commissioning framework.

The key recommendations from the safeguarding and looked after children inspection in 2010 and the 2012 child protection inspection have been implemented and progress has been sustained, resulting in improved outcomes for many children. Some work is required to ensure that all strategy discussions benefit from a fully comprehensive multi-agency sharing of information before actions are taken. Assessments for disabled children do not always fully consider the impact of disability on their everyday lives. Highly effective multi-agency systems that provide help to families reduce the demand for statutory involvement with social care. When children do need help and protection they receive appropriate good-quality services. Arrangements for dealing with contacts and referrals are effective and decisions made are appropriate and timely.

The level and depth of meticulous management oversight given to children at every stage of the care and court planning process is an area of outstanding practice. Outcomes for children who have returned home on care orders are tracked by the service and any practice issues and learning are shared at The Merseyside and Cheshire Local Family Justice Board. This ensures timely action, prevents drift and delay for children and provides a good opportunity to share wider learning.

Children who are looked after are well supported. Planning for children's permanence happens without delay and plans are actively progressed and robustly challenged when necessary by independent reviewing officers. Some assessments of children looked after are not updated regularly enough to reflect current needs and circumstances. Additionally the plans resulting from such assessments do not always have specific targets for improving outcomes for children. Effective work is

undertaken by the local authority within the courts. Care applications are timely and of good quality, leading to the completion of legal proceedings within expected timescales.

Placement stability is good and the vast majority of children looked after live with a foster family or are placed for adoption. A robust, analytical sufficiency strategy is comprehensive and clearly sets out how future needs will be met. It includes appropriate targeted recruitment of carers for larger families and older children. The local authority has increased the number of children looked after who have their health needs assessed and have dental checks completed on time, but delays occur in this area for some children. Similarly, while life story work has been started for most children in long-term foster care, there is delay in completion of this work in too many cases.

Outstanding practice in the adoption service means that children are considered for adoption at an early stage and creative family finding means that brothers and sisters are adopted together and children who are considered difficult to match are adopted. Performance against the adoption scorecard is very strong and reflects the excellent practice in the service of robust case tracking to prevent delay and fast tracking second-time adopters.

Care leavers benefit from good, trusting relationships with their personal advisers, who make strenuous efforts to keep in touch with them, helping and supporting them through the transition to independent living. Care leavers are provided with grants to set up a home plus ongoing financial support. In addition, they are helped to access local community health services. A good health passport scheme is in place for young people aged up to 18 but presently does not include older young people to understand their full health history. Young people feel safe where they live and there is a good range and choice of accommodation.

A strong culture of performance management and quality assurance encourages learning and continuous improvement throughout the children's social care and early help service. Social workers feel valued and supported by their managers and enjoy working in the service. Workforce stability and sufficiency is a priority for the local authority, which has taken action to ensure that there is a fully staffed service at all times.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates three children's homes. Two were judged to be good or outstanding in their most recent Ofsted inspection.
- The previous inspection of the local authority's safeguarding arrangements/arrangements for the protection of children was in October 2012. The local authority was judged to be adequate.
- The previous inspection of the local authority's services for looked after children was in November 2010. The local authority was judged to be inadequate.

Local leadership

- The director of children's services (DCS) has been in post since January 2011. He is also the DCS in Halton.
- The chair of the LSCB has been in post since January 2014.

Children living in this area

- Approximately 66,157 children and young people under the age of 18 years live in Cheshire West and Chester. This is 19.9% of the total population in the area.
- Approximately 15.7% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 12.3% (the national average is 15.6%)
  - in secondary schools is 9.5% (the national average is 13.9%).
- Children and young people from minority ethnic groups account for 4% of all children living in the area, compared with 21.5% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Mixed or Asian and Asian British.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 4.3% (the national figure is 19.4%)
  - in secondary schools is 2.9% (the national figure is 15.0%).

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

Child protection in this area

- At 31 October 2015, 2,088 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 2,147 at 31 March 2015.
- At 31 October 2015, 268 children and young people were the subject of a child protection plan. This is an increase from 246 at 31 March 2015.
- At 31 October 2015, three children lived in a privately arranged fostering placement. This is a reduction from six at 31 March 2015.
- Since the last inspection, five serious incident notifications have been submitted to Ofsted and two serious case reviews have been completed or were ongoing at the time of the inspection.

Children looked after in this area

- At 31 October 2015, 471 children are being looked after by the local authority (a rate of 71 per 10,000 children). This is a reduction from 500 (75 per 10,000 children) at 31 March 2015. Of this number:
  - 195 (or 41.4%) live outside the local authority area
  - 17 live in residential children's homes, of whom 58.8% live out of the authority area
  - 12 live in residential special schools,[3] of whom 100% live out of the authority area
  - 310 live with foster families, of whom 43.9% live out of the authority area
  - 69 live with parents, of whom 13% live out of the authority area
  - one child is an unaccompanied asylum-seeking child.
- In the last 12 months:
  - there have been 23 adoptions
  - 40 children became the subject of special guardianship orders
  - 175 children ceased to be looked after
  - 10 children and young people ceased to be looked after and moved on to independent living
  - eight children and young people ceased to be looked after and are now living in houses of multiple occupation.

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

Recommendations

1. Ensure that information is gathered from all relevant agencies to inform strategy discussions and meetings in order to gain all information before decisions are made (paragraph 15).

2. Ensure that assessments for disabled children fully consider the impact of disability on their everyday lives (paragraph 30).

3. Ensure that children looked after's health needs are assessed in a timely way and extend the health passport scheme to all care leavers (paragraph 53)

4. Continue with and strengthen the work done by the virtual school with children looked after at Key Stages 3 and 4 to increase their progress and attainment (paragraph 57)

5. Ensure that assessments of children looked after reflect their current needs and circumstances and that care planning documentation has targets for improvement that are clear and prioritise the most important issues for children and young people (paragraphs 40 and 42).

Summary for children and young people

- Senior managers have worked hard to improve services for children and families and have made good progress since inspectors last visited. They have spoken with children and young people and listened to what they have had to say. Because of their work, children are kept safe and the help they are given improves their lives.
- Professionals such as social workers and teachers work well together to give children and families the help they need when they need it. This often means that the difficulties they have do not become more serious. Social workers and other professionals keep good records so that they are able to make the right judgements about the help children and young people need. They are especially good at finding out what help babies and their parents need before the baby is born.
- Social workers support families well to keep children at home but make the right decisions about when children must be taken into care.
- Young people who are members of the Children in Care Council told us that they feel safe where they live and are well supported by their social workers.
- Social workers are good at identifying when children are at risk of being sexually exploited. Children who go missing from home are spoken to quickly by expert staff and given help them to avoid problems in the future. When children go missing from school, staff work hard to find them and make sure they are safe.
- Professionals know children and young people well, and help them to understand their problems and make plans to solve them. However, when they write plans down sometimes they do not include targets to make it easy to see how well children are progressing.
- Managers and social workers make good arrangements so that children who are looked after can stay permanently with the same foster carers. This makes their lives more stable; children in care are well looked after and are happy. Arrangements for adoption are excellent. Workers make sure that adopters can offer a good home to children, including those with special needs. Staff work hard to match children with potential adopters and to make the adoption process as quick as possible. They provide good help to support families once the adoption is complete.
- Social workers help young people stay with foster carers until they are ready to leave. Young people who leave care are helped to find a good place to live and to learn how to live on their own. Professionals are working hard to ensure that young people who leave care have a good choice of accommodation to move into, even in an emergency.
- Although looked after children attend a school that is right for them, too few do well enough at secondary school and this affects their chances of becoming successful adults. Too few continue in education or gain an apprenticeship once they leave school.

- Social workers sometimes are too slow completing work with children to help them understand their life story, something that helps them make sense of their place in the world.

The experiences and progress of children who need help and protection	**Good**

Access to appropriate, effective help and support combined with a wide range of good services are provided at the right time to meet the needs of children, young people and families. As a result, risks are minimised and outcomes improve for the majority of children. Multi-agency, community-based early support is well co-ordinated and timely. This means that needs are identified and appropriate early help interventions prevent problems escalating.

Partner agencies have a good understanding of the thresholds for referral for early intervention and children's social care. This ensures that children are referred to the appropriate agency for help. Children at immediate risk of harm are responded to in a timely way and swift action is taken to ensure that they are safe. However, not all strategy discussions benefit from the widest possible range of partner agencies being consulted until after enquiries have commenced.

Timely assessments make effective use of historical information. Children's wishes and feelings are well recorded and all children have access to independent advocacy. Assessments lead to the development of multi-agency plans that improve outcomes and reduce risk for children. Disabled children are well supported and have access to a range of good and helpful services. However, some assessments for disabled children do not fully consider the impact of individual disability on the everyday life of the child.

A wide range of effective and appropriate service provision is available at all levels of need for children who are at risk of harm as a result of domestic abuse. Children are well supported due to increasingly effective early identification and intervention.

Assessments of young people who present as homeless are completed in a timely way and this results in support via multi-agency plans that address their needs.

Effective and established systems are in place to identify and evaluate risk for children who go missing or who are at risk of child sexual exploitation. Children and young people are responded to with a range of appropriate support to intervene and reduce harm.

Inspection findings

6. Robust, co-ordinated and effective multi-agency early help services provided to children and families prevent the need for escalation to more targeted services in many cases. The Early Support Assessment Team (ESAT) and Integrated Early Support (IES) service established in 2013 have improved access to early help by providing a central point of contact. As a result, robust case management of team around the family (TAF) arrangements supports and helps families who do not meet the threshold for intervention from children's social care.

7. The Troubled Families programme is fully integrated into the Early Support Service, providing effective support for families with good tracking systems in place to monitor outcomes.

8. An effective central point for all early help referrals ensures that robust information gathering takes place from a wide range of agencies to inform decisions about next steps and get the right services in place to help children. Referrals for early help support are discussed at weekly multi-agency locality case management meetings to ensure effective information sharing and provision of service by the right partner agency. Robust recording of consent by families to share information is recorded on files.

9. Multi-agency locality teams develop good-quality TAF assessment and plans to provide services to meet need. Assessments are detailed, including recording of the child's voice and the views of parents and other significant adults. In many cases, there is good evidence of direct work with children and the use of assessment tools and other resources by workers. Assessments result in good-quality plans with specific targets and actions and clear consideration of contingency planning to support families and reduce risk to children.

10. The local authority has made significant progress towards developing an integrated electronic case management system for early support and is using innovative technology to support successful partner contribution to TAF. Improvements in the way that progress on case work is recorded and monitored are enabling better understanding and monitoring of the journey of children across the continuum of need. This has resulted in improved services to individuals and better performance management information to inform wider service development.

11. Effective understanding and application of the threshold between early help and children's social care ensure that children get the help they need from the right service. Cases are progressed to referral and assessment where appropriate, and where needs change they are stepped up or down the continuum of need while retaining a plan that maintains the support being offered.

12. Children's social care respond in a timely way to children identified as at risk of harm and take prompt and effective action to keep them safe. The screening of

contacts and referrals is rigorous and routine consideration is given to historical information. Management oversight of contacts and referrals is appropriate and thresholds are applied consistently. The majority of contacts are notifications from police. The vast majority of these are appropriate and timely and all referrals from the police include a statement of the 'voice of child' which considers the experience of children and improves the quality of the information provided.

13. Children in need of help or protection have their needs assessed promptly and thoroughly with targets for completion being set and based on the needs of the child. The majority of assessments are of good quality, use analysis to come to appropriate conclusions and lead to the provision of appropriate support to help children. The quality of pre-birth assessments is particularly strong and all cases seen were of at least good quality.

14. Children are seen regularly by social workers and their views are recorded clearly on case files to inform assessment and care planning. Social workers routinely visit children and speak to them alone where this is appropriate. Their views are clearly recorded on their case files. Work with parents of unborn children (pre-birth) demonstrates social workers building trusting relationships with parents to obtain their views, which are clearly considered when developing care plans.

15. Timely responses when children are at risk of immediate harm ensure that they are protected and risk is reduced. Qualified social workers undertake effective investigations, children are seen and spoken to, and decision-making is timely and appropriate. Strategy discussions are timely, but occasionally the discussion only includes children's social care and police. This is mitigated in some cases by the information being already available as a result of detailed screening in the Contact and Referral Team or from the referrer themselves. In a small number of cases, work is begun without the benefit of the widest possible consultation with other agencies. However, all relevant agencies are routinely consulted as investigations progress.

16. When children are found to be at risk of significant harm, consideration of the risks at an initial child protection conference is timely and leads to effective multi-agency child protection planning to address and minimise the issues of risk. The number of children on plans for emotional abuse is high at 56% and reflects the increased identification and understanding of the impact of domestic abuse. Children do not stay on plans for too long, with no child being on a plan for over two years and low numbers of children being subject to second or subsequent plans. Children are visited regularly, with 94.8% of visits being within statutory timescales in the last 3 months.

17. Effective quality assurance of conference reports and attendance is provided by child protection chairs, who use escalation procedures where necessary to drive up standards and challenge any delay. Comments from child protection chairs on quality and progress are evident on children's files.

18. All plans seen during the inspection record appropriate multi-agency intervention that is meeting need or reducing risk. However, the recording of some plans does not demonstrate sufficiently clear targets or timescales that can be easily measured. As a result, records do not always demonstrate or do justice to the impact of the help and support being delivered. However, social workers can readily describe and evaluate help offered verbally.

19. Child protection plans are progressed without delay by well-attended, engaged multi-agency professionals at core group meetings. They ensure that appropriate support addresses needs and in most cases, this successfully reduces risk. Core group professionals are fully involved in care planning and contribute to review conferences. Information sharing is good and the timeliness and quality of core groups is monitored and reviewed by child protection chairs.

20. Multi-agency plans offer a range of well-considered help when assessments identify children in need. All children seen during inspection had plans in place that clearly identify the issues they face. A range of appropriate and good-quality multi-agency interventions and services were delivered to meet identified needs.

21. Good work by a range of partner agencies identifies and assesses the degree of risk children may face from sexual exploitation. Screening is well established and undertaken across the partnership. As a result, interventions are delivered promptly and risks are reduced in the vast majority of cases. Screening is consistently undertaken by professionals in all agencies to identify levels of risk to young people from child sexual exploitation. This leads to interventions that successfully address and reduce risk.

22. Responsive and proactive partnership working has resulted in reduced risk to children who are at risk of sexual exploitation. The establishment of a pilot specialist multi-agency team to gather and share information about child sexual exploitation in the borough is providing a range of services to support young people. The cohort of young people at potential risk is well understood and all have multi-agency plans led by children's social care. In addition to undertaking awareness-raising, the team is providing effective support to professionals and intervention with young people, including health assessments and advice and a range of direct work. A further good and helpful development is the new workspace on the electronic record system enabling concerns about child sexual exploitation to be more easily recorded and reviewed. Effective collation and analysis of intelligence has led to further reduction of risk to young people through successful disruption activity in the borough alongside some successful prosecutions.

23. Well-embedded and effective arrangements when children go missing mean that children missing from home are identified by the police and offered independent return interviews through a commissioned specialist service to discuss the reasons for their absence. In many cases, this interview is followed

by direct work that reduces future risk. There are low numbers of young people who repeatedly go missing from home. Good information sharing and joint working between the police and services ensures good understanding of the cohort and any emerging themes or issues.

24. Appropriate links between missing children and the potential for child sexual exploitation are being made by professionals and effective use of the screening tool to identify risk was seen by inspectors. Strategic work in the last 12 months around missing children has focused on ensuring shared understanding, practice and processes in relation to return home interviews. The regular collation of intelligence gathered ensures that professionals have an understanding of the cohort involved and issues as they emerge. This leads to identified themes being considered as part of regular performance reporting to the council and the local safeguarding board.

25. Responses for children missing education are clear, well understood and routinely used. The local authority maintains accurate records of children missing education and vigorously pursues them until their location and educational arrangement are known. Good work with local police ensures that schools are informed and supported when children are affected by domestic violence and this puts them at risk of non-attendance.

26. The children missing education team liaises closely with the Education Welfare team to ensure a joined-up response when children stop attending school. Staff cross-check their information with police and school records of those at risk of sexual exploitation. Children missing education concerns that involve a potential risk of exploitation are referred to social workers and the police without delay.

27. Effective awareness-raising helps professionals identify children living in homes where domestic abuse is present. The response to domestic abuse by children's social care is well developed and co-ordinated and children are being supported through a range of services to help improve their circumstances. In all domestic abuse cases seen during the inspection, appropriate services are being offered to families as part of planning, including perpetrators of domestic abuse being provided with multi-agency response, challenge and support via 'Navigate Safer' and access to a voluntary perpetrator programme. Children and young people are supported well by a range of services including commissioned services providing research-based group work programmes designed to prevent development of aggressive behaviour in teenagers. Services for adult victims include in-house and commissioned services including Gateway, Survivor Recovery Programme (for Adults) and a supportive accommodation service.

28. Regular and consistent attendance at the multi-agency risk assessment conference (MARAC) by multi-agency representatives results in good quality information sharing and actions taken to reduce risk to children and vulnerable adults. They review and risk manage higher-level domestic abuse cases to ensure that families receive the right level of intervention and support. Minutes demonstrate all referring agencies using an agreed risk assessment tool,

sharing information and putting appropriate actions in place to address presenting issues. Actions are followed up by the chair, and if they are not reported as complete then agencies are challenged appropriately. Referrals to the MARAC have continued to increase as a result of greater awareness-raising. Fifty per cent of referrals are from agencies other than the police (155 referrals in quarter two of this year compared with 121 in same quarter of 2014–15). The chair of the MARAC reports good and consistent attendance at multi - agency meetings by named workers from each agency.

29. The IES has been particularly successful in increasing the delivery of early support to families where domestic abuse is identified but where the threshold for social care intervention is not met. This means that children are not left in situations of risk without being given help and support to reduce it. In October 2015, 34% of referrals for early support were in relation to domestic abuse, which resulted in support to 105 children from 55 families.

30. Disabled children and their families are well supported through a range of services to help meet ongoing needs, and parents reported feeling listened to and well supported. Some written assessments are brief, but in all cases seen, the risk analysis was focused, identified future planning and clearly reflected the voice of the child. The recording of plans is not consistently of good quality and would benefit from more detail and greater focus on the impact of disability on the child in their everyday lives. Managers are aware of these issues and are currently undertaking a review of the support offered to disabled children, with initial recommendations expected in January 2016.

31. In all cases seen, young people who present as homeless are appropriately assessed by social workers to identify if they are in need and appropriate support is provided. There are currently no young people in B&B accommodation and there have been no young people placed in such accommodation for the past five months although there were a small number of episodes prior to this time. This was an action of last resort and young people's needs were assessed and they were judged to be low vulnerability before being accommodated there. The DCS has made a personal pledge that they will not be used again. The local authority is giving high priority to this matter and fully understand that B&B is not suitable accommodation for young people. Following a review of its supply of temporary accommodation, six new emergency placements have been acquired to complement existing units available to the local authority.

32. Children in private fostering arrangements are appropriately assessed and statutory requirements are met. This could be improved further through having more focused oversight for decision making in respect of private fostering to monitor the quality assurance of private fostering arrangements and to ensure that the statement of purpose and annual report fully describe the awareness raising that has taken place and its impact.

33. Robust arrangements for the notification and investigation of abuse or poor practice by adults working with children are in place. The annual report is clear, accessible and includes essential performance information. The majority of referrals are dealt with in a timely manner. Records are kept separately from the main IT system and are not accessible to other managers in the authority. Cases seen proceeded to timely strategy meetings that are well recorded and well managed, with all risks identified and appropriate actions specified and followed up. This includes robust enforcement of learning and disciplinary action in both cases. Appropriate designated officer practice was also evidenced in case work sampled by inspectors.

34. Access to independent advocacy is available for children and young people to support them in ensuring that their views are heard as part of child in need or child protection procedures. There is evidence that this service is well promoted and used by a growing number of children to effectively support their involvement in their own care planning. This is good practice and needs to continue to be expanded to a larger number of young people. Child protection chairs recommend advocacy as part of the outline plan but this is not followed up in all cases.

35. An organisation is contracted to deliver appropriate and well-considered children's rights advocacy and independent visitors for all children receiving a service from children's social care including looked after children, children in need and children on child protection plans. Children are supported to get their thoughts and feelings heard in core groups and reviews and are also supported to raise issues such as problems with placements or with contact arrangements.

The experiences and progress of children looked after and achieving permanence	Good

Summary

In Cheshire West and Chester, decisions for children to become looked after are timely and based on thorough risk assessments. All work completed as part of the Public Law Outline is rigorous and effective. Senior managers closely track the progress of children throughout, ensuring that there is no drift. The quality of assessments and plans to support applications to the court are good, and timeliness of court proceedings is very good.

Independent reviewing officers (IROs) are proactive and tenacious in their oversight of the service. Their additional oversight of children placed out of area ensures that children are not disadvantaged by distance. Children spoken to during the inspection highly valued their relationship with them.

Children and care leavers who have additional vulnerabilities due to going missing or who are at risk of child sexual exploitation benefit from swift multi-agency action to reduce risk that is based on a sound analysis of their circumstances.

The vast majority of children live in stable placements with carers who meet their needs well and have appropriate levels of contact with people who are important to them. Almost all children are thriving. However, their educational outcomes at Key Stage 4 require improvement and more work needs to be done to assure timeliness of routine health and dental checks.

Assessments of looked after children's needs are generally good but they are not updated regularly enough. Care plans while considering children's needs do not always demonstrate a consistent level of analysis and rigour and often do not reflect the high-quality work undertaken with children and families. Pathway planning supports and challenges young people, but written targets need to be improved

Most care leavers live in suitable accommodation and are supported well to develop the skills they need to live independently. Their access to education, employment and training, including to local authority apprenticeships, needs improvement and they do not always have enough information about their family medical history.

Numbers of children made subject to special guardianship orders or who are adopted are high and increasing. The local authority provides good, often creative financial and practical help and assistance to these families. Performance on the adoption scorecard is consistently good, improving and the best in the region. This, combined with effective work to keep children out of care and to support children to safely return home, means the numbers of children who need to be looked after in Cheshire West and Chester are decreasing.

Inspection findings

36. Decisions to look after children are appropriate and proportionate in cases seen and in almost all cases involved no delay. Responses to children and families who are at risk of children becoming looked after are robust. When children are not at immediate risk, the edge of care service, which started in June 2015, offers planned and purposeful work using evidence-based practice. In some cases seen this helped young people to remain at home with parents and in others it assisted families to make informal appropriate arrangements within the wider family to avoid the need for the child to become looked after by the local authority.

37. The vast majority of children who are looked after are subject to a care order or interim care order. Only 11% are subject to voluntary arrangements under section 20 of the Children Act 1989. Senior managers and independent reviewing officers monitor these children closely to ensure that they are not subject to voluntary arrangements inappropriately.

38. The local authority's management of cases at every stage within the Public Law Outline (PLO) is effective and robust. Good use of tracking documentation by senior managers at every stage in the child's journey ensures that any potential delay is identified, understood and responded to appropriately. Letters before proceedings clearly explain to parents the local authority's concerns and are underpinned by clear contracts of expectations that outline in detail the required changes. As a result, parents understand what is expected of them and, in some cases seen, were assisted to make sufficient changes so that the threshold for court proceedings was no longer met.

39. Cafcass and the judiciary report that Cheshire West and Chester generally performs well in all aspects of court work. The quality of reports and assessments provided to the court is good and cases generally come to court well prepared and at a time that is right for children. As a result, the timeliness of court proceedings is good. In 2014–15, the average duration was 26 weeks, matching expected timescales. The year to date figure for 2015–16 is 27 weeks, demonstrating consistently good performance. In cases seen where there was delay it was purposeful and led to good outcomes for the children concerned.

40. Assessments of children who became looked after recently are generally of good quality. A few are very good, drawing on research and family history, resulting in appropriate next steps. However, despite clear practice guidelines assessments of children looked after are not always updated frequently enough, even when children's circumstances significantly change. Updates of children's circumstances are included within care planning documents but do not contain the required degree of analysis. Assessments to inform planning for permanence such as viability assessments and 'together or apart assessments' are timely and of good quality.

41. Care planning meetings are held prior to reviews for children looked after as a means of ensuring that the review itself is child-focused and only those people invited by the child can attend. Timing of these meetings is variable and a minority take place too soon before the review, meaning that reports from the meeting are not available to the IRO and the child in advance. The local authority recognised this was an area for improvement prior to this inspection and IROs have provided staff with training and guidance. Records of care planning meetings and children looked after reviews seen by inspectors were directly written to the child and reflected the child's lived experience very well.

42. Care plans overall require improvement. Their format does not assist social workers to prioritise actions that will make the most difference for children. Many plans seen confused needs with actions, were often too generalised to assist families or carers to understand the detail of what was expected of them and did not have clear measures of success. However, parents spoken to by inspectors said that social workers had been clear with them what needed to change and why, even if it was not always clearly reflected in the written plan. In the vast majority of cases seen, outcomes for children had improved despite the deficits seen in written plans.

43. The majority of social workers spoken to during the inspection knew the children they were working with well and ensured that their wishes and feelings were elicited through a variety of means including direct work and observations of younger children. The vast majority of statutory visits (96%) are undertaken within local expected timescales, which are shorter than statutory timescales, and many young people are seen more frequently according to the needs of the case. In all cases seen children were seen alone when appropriate to do so and time taken to discuss key issues that were important to them. These included contact with family members, school and health. However, children spoken to by an inspector had experienced multiple changes of social worker in the past, making it difficult for them to invest in these relationships. In a small number of cases (4 of 17), changes had been very recent. In these cases, IROs had remained a stable figure for the child. All young people spoken to value the relationship they have with their IRO.

44. Social workers pay good, sensitive attention to meeting children's identity needs arising out of disability or their sexuality and all children live in placements that can meet their cultural and ethnic needs. Although inspectors saw some good examples of wider identity needs being considered, such as impact of parenting on children, these were a minority.

45. The IRO service is managed effectively and staff fulfil their statutory functions of review quality assurance and challenge well, contributing to improved outcomes for children. Caseloads, although slightly higher than nationally recommended levels, are manageable. As a result, IROs are able to ensure that they maintain increased contact with children who are particularly vulnerable, for example those placed out of area. In 2014–15, timeliness of reviews was good, with 98% held within statutory timescale. As of September 2015,

unvalidated data provided by the local authority show that 90% of children and young people participated in their review, which represents very good performance. In all cases seen by inspectors, children attended their review or had had contact with their IRO, including in between reviews.

46. IROs ensure planning for permanence is considered at the second and every subsequent review. This, combined with a clear commitment throughout the organisation to consider permanence in all its forms, has led to more children achieving it. In 2014–15, 24% of children left care through special guardianship, double the percentage in 2013–14 and slightly higher than the number who left care through adoption. This demonstrates that good effort is made to reduce the number of moves for children and to keep children living within their own family if possible.

47. As of March 2015, 71% of children looked after lived with foster carers or were placed for adoption and 5% of children lived in children's units or homes. This ensures that the majority of children looked after experience the benefits of family life. The majority of children live in placements that are close to their family and friends, with 82% living within 20 miles of home. The majority of children who live further afield are in specialist placements due to their complex and multiple needs. In cases seen by inspectors these placements were meeting children's educational and health needs well and children were supported to have appropriate contact with the people who are important to them. At the point of placement, no children are placed in provision that is judged to be less than good by Ofsted. In the minority of cases (6%) where a child is in provision that requires improvement, decisions about continuation of the placement take into account how well it is meeting the child's needs, wishes and feelings and the quality of the setting's improvement plan. This means children are not moved unnecessarily. The Access to Resources team is vigilant in ensuring that provision which is regulated by the Welsh Inspectorate, which does not provide graded judgements, and unregulated provision for care leavers is of good quality.

48. Most children live in stable placements. At the time of the inspection, 7% of children who had been looked after for 12 months had three or more placement moves. This is an improvement on the last published figures for Cheshire West and Chester in 2013–14, which at 10% was better than statistical neighbours and North West averages for that year. Long-term placement stability, while not as strong, is improving. At the end of quarter two, 2014–15, 68% of children looked after had been in the same placement for at least two years. As a result, increasingly more children are benefiting from the opportunities to develop enduring relationships with carers and the community they live in that a stable placement affords.

49. Where children are placed with parents or there is a plan to return them to their parents' care, arrangements are informed by robust assessments that include analysis of parents' capacity to sustain positive change. Returns home are well planned and children and families receive good, timely and, where

indicated, intensive support and oversight. If circumstances deteriorate the local authority acts swiftly to secure appropriate alternative arrangements.

50. The local authority has a detailed understanding of the looked after population and its sufficiency strategy is well informed by a robust analysis of present and future need. This means that the local authority is well placed to provide quality services for children now and in the future. Recruitment is targeted at finding carers for children who have the most need, such as teenagers and larger families. A net gain of five carers was achieved in 2014–15 as a result of these efforts. Use of good-quality independent provision supplements the local authority's own resources and has ensured that the vast majority of children live in placements that match their needs and that they are not separated from their brothers and sisters. At the time of the inspection, one group of children assessed to live together were living apart. This was due to the complexity of their family arrangements rather than a lack of appropriate resource.

51. Foster carers spoken to by inspectors are highly appreciative of the support they receive from supervising social workers and children's social workers. Foster carer training is comprehensive and appropriately linked to national minimum standards. At the time of the inspection, 88% of carers had completed the training support and development standards workbook within 12 months of approval. Arrangements for delegated powers are clearly negotiated on a case-by-case basis and commensurate with children's care plans, age and needs. As a result, children benefit from a more 'normal' family experience, negotiating with carers in the same way their peers do with their families.

52. Until recently, delays in children completing life story work meant some children waited too long before receiving the help they needed to understand their history. The local authority has prioritised its completion, providing good-quality training to workers. As a result, social workers for 39 out of 198 children in long-term foster placements who need life story work have completed it, and a further 137 have life story work in progress. It is not appropriate for the remainder to start life story work at this time.

53. Despite focused work and a range of initiatives to promote the health of children and young people, the local authority has not yet assured itself that enough young people's basic health needs are assessed and met in a timely fashion. Unvalidated figures provided by the looked after children health team show that 76% of children and young people had had dental checks at the time of the inspection. While still too low, it represents considerable improvement from most recently published figures for 2013–14 (62%). Long-standing issues in relation to the timeliness and quality of health assessments have recently been addressed through the development of clear pathways and escalation policies. In September 2015, 100% of initial health assessments were completed on time, meaning that any health issues are identified and addressed early and children receive any specialist help they may need in a timely way. This compares to 64% in August and only 32% in July and demonstrates the improved focus that has been applied to health assessments.

54. Until December 2015, children looked after who had additional needs as a result of their emotional or mental health received a service from a dedicated team, 'Caring to Care', provided through a commissioned service. The service provided support for a wide range of emotional and behavioural issues including to children placed out of area within 40 miles of the local authority boundary. Waiting times for assessment and intervention at the beginning of this financial year were far too long. In quarter one of 2015–16, children who needed direct work waited almost six months on average to receive a service. In quarter two, this significantly improved to an average of 40 days. A newly commissioned service started in December 2015. It is too early to evaluate its effectiveness. Good transition arrangements have ensured that children's access to treatment has not been delayed during the changeover.

55. The virtual school works closely with schools in the authority to improve the educational experiences of children looked after. Routine contact with school staff is also kept when children are placed outside of their local area. The large majority of these children attend a good school. Where they do not, it is considered to be in the best interests of that particular child to enable them to remain in a school where they are settled well and achieving or to stay close to home or brothers and sisters. Staff of the virtual school monitor closely the attendance of children at school and provide teachers with timely and effective support when difficulties arise. As a result, the school attendance of children looked after is high (97.1% sessions attended in 2013/14). Staff of the virtual school provide good opportunities for teachers and governors to develop the skills and understanding they need to work effectively with children looked after through a well-considered range of training events and frequent cluster meetings at which teachers can share experiences and good practice. Virtual school staff work well with teachers to address issues of bullying and harassment of children looked after.

56. Virtual school staff, social workers and teachers work quickly to ensure that all children have a personal educational plan (PEP) as soon as they enter care. Virtual school staff are meticulous in ensuring that these plans are reviewed and updated once per term and, wherever possible, involve the child. However, although children's needs are assessed well, in around half of all PEPs action plans are insufficiently detailed or specific to measure progress. Virtual school staff are aware of this, and have prioritised improvements over the coming 12 months. PEPs are used effectively to plan and review Pupil Premium Plus spending through a clear bidding and review process and this ensures that interventions help improve children's academic attainment.

57. The progress and attainment of children looked after has improved and is strong up until the end of Key Stage 2. Children make good progress from their starting points in reading, writing and mathematics and by the end of primary school attain in line with all other children. However, the progress children looked after make in secondary school is insufficient. Few gain a good range of GCSEs at grades A* to C, despite a range of appropriate interventions from the virtual school. Many young people enter care in Years 10 and 11, making it

difficult for them to make up for time lost in earlier years. A small number missed by a single grade the target of five GCSEs at grade A* to C including English and mathematics.

58. Children for whom attendance at school is difficult have access to appropriate alternative provision. The virtual school works closely with schools to support the small number of children who are unable to benefit from 25 hours of education per week and these children follow appropriate programmes that are well matched to their needs.

59. Children who are looked after who go missing from care benefit from the same robust multi-agency response as children who go missing from home, including for children placed out of area. In the second quarter of 2015, 59 children looked after were reported as missing. Return interviews were offered in all cases and in 61% of cases took place within 72 hours of the missing episode. Almost all interviews sampled (seven of eight) were detailed, including analysis of risk. Timely services were provided where needed. Use of a comprehensive screening tool ensures that additional vulnerability to child sexual exploitation is considered when children go missing.

60. When risk of child sexual exploitation is identified, multi-agency risk management meetings are swiftly held. Those seen were well attended by key partner agencies and resulted in comprehensive plans to reduce risk to children who were victims or perpetrators of child sexual exploitation. When risk does not reduce or is escalating, robust alternative action is taken to protect children, for example a change of placement to reduce proximity to known triggers, serving of child abduction notices or, where necessary, use of secure accommodation.

61. Children and young people have access to a wide range of social and educational opportunities. Carers are provided with discount cards for attractions and free leisure passes and in cases seen, children's hobbies and talents were encouraged and achievements celebrated.

62. Children looked after are represented well by an active and enthusiastic Children in Care Council that is representative of all children looked after including disabled children and children placed out of area. The young people meet on a regular basis (in two age groups) and make a positive contribution to service development that is helping to drive up standards such as visiting housing provision and helping to design a new residential unit.

The graded judgement for adoption performance is that it is Outstanding

63. The local authority gives high priority to promote permanence for children through adoption and this is embedded in the culture of social work practice. Adoption policy, procedure and practice is sharply focused on delivering the best possible permanence outcomes for children. Arrangements for creative

financial and practical help and assistance for adopters is a strong feature of the service. Children who may be in need of adoption are identified at an early stage in the planning process. This work is characterised by twin tracking arrangements that start at the pre-proceedings stage. This work is underpinned by effective legal gatekeeping meetings to ensure that all permanent options are explored rigorously and early. Children do not experience needless delay through care proceedings. Every child's progress is tracked, so that managers and social workers are sharply focused on what they need to do and by when. The effective use of data supports robust reporting arrangements so that managers are equipped with the information they need to make decisions.

64. The local authority adoption recruitment strategy is highly successful, resulting in more than enough adopters in the borough to meet the demand for this type of family placement. This promotes choice for children, leading to better outcomes. It has also enabled the local authority to contribute to the National Adoption Register. Adopters report that they are attracted to Cheshire West and Chester local authority because of the quality of the adoption literature, the effectiveness of the targeted recruitment campaigns and the speed with which social workers make the first contact.

65. Case records show good engagement with prospective adopters to ensure their suitability as part of the assessment process. Pre-adoption reports are carried out in a timely fashion. The quality of these reports is consistently good and they provide a sound basis for the Adoption Panel to make decisions on approval. Adopters report that the assessment process is made clear and is transparent throughout. Reports focus on what they need to and social work practice is sensitive but robust to determine suitability.

66. Family finding is purposeful and effective so that there are no children waiting for a match. For example, action to support family finding for children from ethnic minority groups starts early, even before birth. At the time of the inspection, there were nine children with a decision to adopt, of which eight were on Interim Care Orders with potential matches awaiting the court decisions and one with a Placement Order has already been matched. There were 28 adopters without a placement and one of these had a potential match.

67. All prospective adopters are approved by the Adoption Panel without delay. Decisions are signed off by the Agency Decision Maker (ADM), who is at an appropriately senior level in the local authority. The Adoption Panel chair is qualified, experienced and sufficiently independent of the local authority. The panel membership provides a good balance of social work professionals, other professionals and adopters, including members who are from the ethnic minority population. Checks on those approved for adoption are rigorous. The Adoption Panel has carefully considered recommendations leading to 55 adopters being approved in 2014–15, with a further 22 approvals since April 2015. There is a rigorous approach to the quality of matching children with adopters. Social work reports are always of good quality, sensitively written and child-focused to support the Adoption Panel in their recommendations. The

Adoption Panel chair and the ADM meet quarterly to ensure the early identification of issues and actions to enable the smooth operation of the service. For example, the frequency with which the panel meets has increased to manage the rise in numbers of fostering-to-adopt applications.

68. Children are placed successfully. Permanence through adoption is effective for a high majority of children characterised by the local authority's track record, with only a small number of revocations of Placement Orders. For example, over a two-year period from 2013–15 only two families experienced this change in the route to permanence. The local authority gives high priority so brothers and sisters can live together wherever possible. For example, of the 31 children adopted in 2014–15, eight out of the 10 children who were part of sibling groups were placed together.

69. The local authority has been quick to respond to the changes in policy around concurrent planning and has a well-established fostering-to-adopt approach that is used to full potential as an option for permanence for children. Innovative practice has led to 10 children benefiting from permanence through this route since December 2013. This is very good performance and has demonstrably improved outcomes for the children involved.

70. The local authority gives high priority to adoption support. There is a wide range of effective pre- and post-adoption support that is embedded. This includes training, group activities, seminars and individual one-to-one arrangements to meet the holistic needs of adopters and children, including those children with complex needs. The number of adopters who are engaging with this support is increasing year on year. Adopters report that the support they receive is appropriate, available for as long as they want it and highly valued. The local authority has been proactive and effectively utilised the Adoption Support Fund to deliver this programme of work.

71. There are many examples of excellent practice to support children and families, such as the weekly teens adoption support group, known as the 'TAG group'. Teenagers use this group to discuss a number of complex issues such as relationships, mental health, self-harm and behaviour management. Workers help young people to understand adoption, meet other young people who are adopted and encourage peer support where this is appropriate. This work is highly valued by parents. The TAG group has directly helped to prevent placement breakdown and has helped to identify additional support that families need to access. The Approved Adopters Support Group, for carers approved but who as yet do not have a child, meets regularly to ensure ongoing momentum and engagement. The group allows carers to share their experiences of searching for children to adopt and as 'up and coming first time parents', and many develop relationships with other prospective adopters, which they find helpful. This has proved invaluable for retaining this group of adoptive carers. There are examples of highly effective work to promote adoption for children with special needs, such as better targeting through the

use of Adoption Link, leading to successful family placements for this hard-to-place group of children.

72. Performance on the adoption scorecard is consistently good, improving and the best in the high-performing North West region. The latest published three-yearly figures for 2011–14 show that the average time between a child entering care and moving in with their adoptive family is 476 days, which is better than the national average of 628 days by 152 days. Year-on-year performance is also good. Data from the Adoption Leadership Board return for 2014–15 show that performance has improved from the previous year and is 422 days. The latest published figures for 2011–14 show that the average number of days between receiving court authority to place a child to be adopted and the local authority deciding on a match to an adoptive family is 135 days. This is better than the national average of 217 days by 82 days and above the national scorecard threshold of 152 days by 17 days.

73. This sustained good performance is underpinned by two key initiatives: the robust arrangements for tracking cases early from the pre-proceedings stage and 'fast tracking' for second-time adopters to reduce any delay. This means that while their assessments still go to panel for approval, they are prioritised as known carers and are especially more likely to be able to take siblings if needed. The latest published figures for 2011–14 show that the percentage of children who wait less than 18 months between entering care and moving in with their adoptive family is 69% for 2011–14, significantly better than the national level of 51% and above the statistical neighbour level of 50%.

74. Direct work with children and adopters is underpinned by the high quality of social work practice, which is creative and of the highest standard, and ensures that needs are comprehensively met. Social workers and their managers are passionate and tenacious in their efforts to secure the best possible outcomes for children and families. Social workers' relationships with adopters are well developed. Life story work seen is good quality; written in child-friendly language and supported by extensive use of pictures. Later life letters are sensitively written and 'letter box' is used extensively so that contact arrangements are secured for children and their birth families. Close scrutiny of the local authority's own data show that a high proportion of the children looked after population leave care through adoption. For example, this was 21% in 2014–15, which is in line with comparators whose average is also 21%. Children placed for adoption are thriving and outcomes are demonstrably improved for these children.

75. Although the work of the Adoption Panel is subject to an annual report and six-monthly report to meet requirements, the report is focused predominantly on panel activity. The opportunity is missed to evaluate some key areas of the service operation. The panel chair has identified this as an area for development to support ongoing improvement as the local authority strives for excellence. This will ensure that data on the performance of the children's

social care teams and the adoption team are reported, so that the Adoption Manager has a holistic overview of the adoption service operation.

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

76. The local authority makes strenuous efforts to maintain contact with care leavers and is in touch directly with 103 of the 125 (82.4%). The majority of the remaining 22 young people have contact with other services and do not want contact with the local authority or have returned to live with their family or friends and choose not to have contact, but the leaving care team know where these young people are. Of those with whom the local authority is in contact, 93.2% live in appropriate accommodation and the vast majority are happy with their arrangements. The young people spoken to reported no concerns about their personal safety in their accommodation. Partnership work through the local authority's strategic housing department and a number of housing associations is well developed, ensuring that the needs of care leavers are met by, for example, ensuring that care leavers can live in the localities they know, so that they feel safe and supported by friends. Social landlords work closely with care leavers and their support workers to identify and mitigate risks of tenancy breakdown and consequently these are rare.

77. Members of the leaving care team work with young people between the ages of 15 years and nine months and 16 years and three months to develop their pathway plan. This work is continued by social workers and personal advisers, who review progress and update plans every six months. Support workers know their young people extremely well and use the pathway planning process to challenge them effectively. Pathway plans document clearly the needs of care leavers, but in around half of all those seen, action plans would benefit from increased focus to comprehensively support young people to make rapid improvements in their life. Care leavers trust their social workers and personal advisers and value the opportunity the pathway planning process gives them to explore the issues that affect them.

78. Careful assessment of young people's health needs is undertaken during visits by social workers and personal advisers including issues around substance abuse and sexual health. They help care leavers to register with doctors, dentists and opticians and encourage them to have regular check-ups. Where care leavers are living semi-independently, support workers help them to access services by, for example, taking them to appointments. Young people have said that where they have particular needs, their personal adviser provides help quickly and effectively.

79. Useful health information is given to children looked after over the age of 14 in a health passport at their review health assessment. This initiative has not yet been offered to care leavers over 18, although managers plan to include it in

pathway planning. Young people receive a 'Me and my health guide' before they leave care as part of their preparation for independence. This is improving their understanding of their basic health history during their time in care, but they do not currently receive enough information about their family health history. The local authority recognises this is an area where further work will be beneficial.

80. The local authority helps younger care leavers through a range of supported accommodation, including support from an overnight support worker, followed by daytime support and moving to full independence. Young people speak positively of the support they are given and are confident that they will be ready for fully independent living when the appropriate time comes. Care leavers are all given a copy of the pledge and are helped by personal advisers to understand their legal rights and entitlements such as access to their records and the right to financial support.

81. Young people told us that they are helped by their social workers and support workers to develop the skills they need to be successful adults. This support commences while the young person is still in care and continues through regular meetings with support workers during the young person's transition to adulthood. The local authority provides appropriate financial support through setting up home allowances, the children's trust fund, payments at birthdays and Christmas and small incentive payments for engaging in education and employment. It supports financially those young people who go to university. Sixteen young people are currently following higher education programmes on a full-time or part-time basis.

82. Social workers encourage 16- and 17-year-olds to remain in care until they are 18, and currently 92 of 95 young people in this age group have chosen to do so. This is an excellent indicator that young people are receiving ongoing practical and emotional support while preparing to live independently. Thirteen of the 125 care leavers aged 18 to 20 have taken advantage of staying put arrangements to remain with their foster carers, which means they are benefiting from living with a family for longer.

83. The local authority employs two education, employment and training support workers. One works with young people to re-engage them in education, training and work and the other is funded through Pupil Premium Plus to support the specific needs of children looked after and care leavers in further education. Fifty-one care leavers (49.5%) do not currently participate in education, employment or training. Of these, 25 are not in education, employment or training for medical reasons or because they are a new parent.

84. Over the last 12 months, 18 care leavers have been employed in apprenticeships, three within the local authority. Managers acknowledge that this is too few and that they have struggled to retain care leavers on apprenticeship programmes because of their lack of work-readiness. To address this, they have engaged a third party to provide pre-apprenticeship training

through a period of focused basic skills training and work experience followed by a tailored traineeship programme and ultimately recruitment to local authority apprenticeships. This is a positive and proactive approach by the local authority but it is too early to judge the impact of the programme.

Leadership, management and governance	Outstanding

Summary

The DCS and his senior leadership team in Cheshire West and Chester have worked steadily and diligently to implement, deliver and oversee good-quality services to meet the needs of children and families. Starting from the time of the 2010 inadequate safeguarding judgement in their safeguarding and looked after children inspection, steady and sustained progress is evident, passing through an adequate judgement in 2012 to this inspection, finding services to be good overall. This outstanding work has included the contribution of managers at all levels of the service.

Political leaders are aware of their duties and responsibilities. They have confidence in the DCS and have developed productive working relationships with him and the leadership team that encourage support and appropriate challenge. Elected members are fully committed to the local authority's priorities and plans for children. The corporate parenting board provides additional oversight and monitoring of services and ensures that young people are engaged in helping to contribute to and influence the services provided.

The local authority is committed to its workforce and has demonstrated genuine commitment to providing a wide range of opportunities and training to help staff develop skills and knowledge. There is an established career structure and staff are supported through regular supervision and the opportunity to reflect upon practice. Staff feel valued and are positive and proud to work in Cheshire West and Chester (CWAC). There is a largely stable and permanent workforce, which means that improvements and learning are driven forward and sustained.

Performance information is well developed and used effectively to facilitate a cycle of learning and improvement. Effective quality assurance systems through regular case auditing lead to improved practice. Social workers and managers are provided with feedback on individual cases. Additionally, findings from case audits are used as themes for reflective discussion sessions for social workers.

Good working relationships with partner agencies have been established through effective strategic work and focus by the Children's Trust, the Health and Well-being Board and the Local Children's Safeguarding Board. These overarching leadership bodies are effective in identifying and meeting local needs through well-embedded commissioning frameworks.

Good strategic and operational partnerships with the police, health and schools are evidenced by an effective early help offer. A wide range of partners identify the needs of children and families at an early enough point to ensure that the problems they face do not escalate.

Senior managers are committed to ensuring that children in this authority are safe and benefit from good and improved outcomes. Children's and families' needs are assessed on a timely basis and services provided as a result. Children are protected

and plans for support and intervention progressed.

Child sexual exploitation and missing from home, care or education arrangements are robust. The strategic director and senior management team have prioritised and focused on these issues and have worked hard to ensure that partners are fully engaged with the agenda. This means they are identifying young people at risk and services are in place to minimise that risk. Partners are active in co-ordinating their efforts, including using disruption methods to reduce risk.

Children in care are looked after well and get a good service from this authority. The authority is effective in ensuring that young people plans are progressed quickly. Strong commissioning arrangements ensure that young people are provided with stable placements and permanency solutions are well considered and implemented.

Young people are well prepared for leaving care and the authority ensures that support remains in place to help them on their journey. Care leavers feel valued and listened to.

Senior managers give high priority to the promotion of adoption to secure permanence for children. They ensure that adoption plans are progressed quickly and that children are placed with adopters as soon as possible.

The authority is forward-looking and has put in place shared arrangements and pooled or aligned budgets that are helping to mitigate economic pressures on services while continuing to provide support to children and families. Many of these arrangements including a shared director of children's services with Halton and a range of shared services – Safeguarding Unit, Commissioning and the headteacher of the Virtual School – are recognised nationally as good practice.

The authority talks to young people and listens to them. Young people in care and those about to leave care are able to influence the local authority through an effective Children in Care Council and Leaving Care Forum.

The authority has taken steps to begin to stabilise its social care workforce, with comprehensive plans put in place to both recruit and retain and develop staff.

Inspection findings

85. The DCS and the senior management team have worked hard over a period of time to drive forward change and progress since previous inspections to develop an effective and responsive service for children and families in Chester and Cheshire West. They have achieved significant and substantial progress through a steady advancement of improvements that have been carefully sustained and embedded.

86. Senior managers, the Chief Executive and political leaders are aware of their respective roles and are well informed about the service and the experiences of families and young people; they know their services well. They are aware of high-profile cases and issues of concern to young people. They are visible to staff and undertake regular visits to front-line services. They discharge their responsibilities appropriately.

87. Governance arrangements are good and secure. The Strategic Director, Children and Families in Cheshire West and Chester is also the director for children's services in neighbouring Halton. This arrangement, in place for the last four years, is supported by the Chief Executive and political leaders in Cheshire West and Chester, who consider that it has facilitated a range of joint working arrangements and budget alignments to the benefit of both authorities. Many of these arrangements are recognised nationally as good practice and include a shared director of children's services and shared services such as Safeguarding Unit, Commissioning and the headteacher of the Virtual School.

88. Members are well informed through service briefings, performance information and reports and have received training in the role of social workers and the social care service. The DCS, Chief Executive, LSCB chair and lead member meet together on a quarterly basis and these meetings are used to identify and highlight areas of progress or concern in relation to safeguarding.

89. An effective whole-system approach to early help, 'Integrated Early Support', was launched in October 2013 to ensure that the needs of families and children were identified at an early stage and help provided. Strong partnerships at strategic and operational levels operate effectively to ensure that children get the help they need from the appropriate service. Significantly, work has resulted in a good and shared understanding of thresholds. The positive impact of the early help offer is clearly demonstrated by 100% of troubled families (525) being turned around, a reduction in reports of anti-social behaviour by 8.6% and a reduction in arrests of 35% for perpetrators of domestic abuse that have progressed through the IES model. Further, a fall in referrals to social care of 10% in the last year links to the impact of the integrated early support model. Robust management of early help services ensures that TAF assessments to families are of good quality. In addition, the authority has invested in further strengthening the quality of the TAF response with the recent appointment of three TAF advisers.

90. The Joint Strategic Needs Analysis (JSNA) is comprehensive and provides the high-level assessment of need to appropriately inform strategies beneath it and across the partnership. The sufficiency strategy is robust, sets out clear priorities and takes a whole systems approach, including prevention, to ensure quality and the provision of a range of placements at all stages of the child's journey. This is based on a comprehensive understanding of current and future need and research findings. The strategy has seen the creation of an edge of care team and the establishment of a new residential unit to respond to the accommodation needs of older young people.

91. The Children and Young People Plan, the Health and Well-being Plan and commissioning arrangements are in place. The Children's Trust and the Health and Well-being Board are appropriately constituted and active in driving plans forward. Plans are focused on identified priorities including the continued improvement of the integrated early support offer together through action planning and appropriate reviews of progress. The leader chairs the Health and

Well-being Board (HWBB) and the lead member supported by the DCS chairs the Children's Trust and this is helping to ensure that plans are aligned and have sufficient focus on children's needs. The strategy for commissioning identifies core priorities for further development and investment, including improving outcomes for children in care, emotional health and well-being and promoting integrated early support.

92. Commissioning arrangements are well established, with a commissioning framework in place and a dedicated commissioning team providing robust scrutiny of commissioned arrangements and the quality of services provided. Services are required to demonstrate how young people's views have been taken into account. There are examples of services being decommissioned on the basis of poor delivery, demonstrating a focus on quality. There is a range of pooled funding with Halton, including the provision of advocacy services, the Pan-Cheshire Missing Service and the post-adoption service. Regional pooled budgets provide funding for the leaving care regional tender and there are aligned priorities and budgets in relation to speech and language services.

93. Performance information is well developed and provides a clear picture of practice, enabling the local authority to identify where action needs to be taken to address shortfalls. Performance information is available at a local level and front-line managers are encouraged through a challenge and answer format to provide explanations for performance on a monthly basis. This strengthens both the authority's understanding of issues as well as staff understanding of the links between performance data, performance and practice. The authority aligns its performance with ambitious targets monitored on a regular basis. However, not all data collected are routinely analysed and monitored. This applies to areas of activity such as core groups taking place in timescale and attendance by young people at conferences. The result of this is that, because the data are not included in the current score card, the authority lacks a fully detailed overview of performance. Managers acknowledge that this is not comprehensive and have now acted to remedy the matter.

94. An impressive revised quality assurance framework put in place in April 2015 has ensured that an already embedded culture of casework auditing is accurately providing a picture of practice across front-line teams. Inspector's judgements on audited and tracked cases largely mirrored that of the local authority. Front-line managers' and staff's understanding of 'what is good' and consistency of casework auditing is supported by monthly learning from audit sessions facilitated by the quality assurance lead. Quality assurance is further strengthened through the work of the principal social worker and 12 senior practitioners leading peer reflective sessions themed as a result of audit findings. A key role of the principal social worker and senior practice leads is to re-enforce and progress practice standards and support newly qualified social workers thorough their assessed first year of practice. They have created robust action plans focusing on practice progress and appropriately identify key areas for further development including SMARTer plans.

95. Staff supervision is regular and newly qualified social workers report good support through supervision. However, the recording of case supervision overall is variable. Detailed recording was seen on many cases, including reflective practice, but some records are lacking actions and timescales, making supervision less useful as a tool to measure progress.

96. The authority has identified workforce stability and sufficiency as a priority. Workforce planning is robust, with both a workforce strategy covering all of the children's services workforce and a separate but linked social work recruitment and retention strategy. The authority has taken action to have a fully staffed service at all times, with Chief Executive agreement to go beyond the social worker establishment by 12 posts to ensure availability of staff. The authority closely monitors social work caseloads and as a result, social workers have manageable caseloads, helping to improve and assure the overall quality of practice. Staff are positive about working in the authority and feel well supported. In addition, the authority is active in trying to retain staff through a staff development policy including aspiring senior practice leads and aspiring team managers' courses, and is currently developing an aspiring senior manager course, all in conjunction with Bournemouth University. Newly qualified staff are engaged in a well-developed, newly qualified social worker (AYSE) programme with support from senior practice leads as mentors, and the authority encourages social work staff to become practice educators with, as a result, a large complement of students in teams (currently 24). Social work vacancies are low and staff turnover rates are reducing, demonstrating a stabilising workforce from earlier higher levels of staff churn.

97. The local authority has taken a proactive approach to the issue of preventing extremism and has a well-developed Channel Panel established two years ago. In addition, their recently developed overarching 'Prevent' strategy clearly outlines the role of the multi-agency panel to agree levels of risk and to co-ordinate and monitor the impact of prevent activity. The authority and its partners have ensured that significant numbers of multi-agency staff have undertaken WRAP3 (Workshop to Raise Awareness of Prevent) Home Office-approved training, including 162 schools by December 2015.

98. The local authority's and partners' strategic approach to child sexual exploitation and missing from home and care is effective and well developed. The local authority is part of the pan-Cheshire strategic group that ensures strategic planning and direction for children who are at risk or are victims of child sexual abuse or who go missing from home or care and who are at risk of trafficking. Child sexual abuse intelligence has led to successful disruption activity in Cheshire West and Chester and the establishment of a multi-agency child sexual abuse team offers effective co-ordination and oversight of all young people at risk of child sexual exploitation.

99. The authority has effective relationships with the Child and Family Court Advisory and Support Service (Cafcass), the family courts and the local Family Justice Board. This has resulted in improved timescales in private and public

law proceedings (27 weeks on average this year), reducing delay for children and young people. Both Cafcass and the judiciary report that Cheshire West and Chester are one of the stronger-performing authorities within the region in all aspects of court work. No cases have been referred back to the local authority by the courts under the local protocol for inadequate practice.

100. The committed and effective Corporate Parenting Panel was re-formed after the May 2015 elections and has had the benefit of the Children in Care Council recently reviewing its working and format and developing a range of recommendations for its members to consider. Members have a commitment to the panel, with the lead member chairing and the leader of the council also in attendance. There is evidence of challenge and consideration of young people's views, for example ensuring that all young people in care received a pack detailing their rights and entitlements after it was raised at the panel by a member of the Children in Care Council. In addition, a decision was taken that all care leavers would be placed in Band A in relation to housing need. The panel has access to senior officers and performance information and councillors on the panel visit children's homes and social work teams on a regular basis, enabling members to be fully briefed on areas of progress and concern.

101. Seeking and recording the voice of the child and their views is a well-established practice and a strength in this authority. Ninety two per cent of young people participate in their reviews (2014–15) and the majority of young people attend personal education and pathway planning meetings. Social work assessments and social worker visits record children's views clearly. Partners also understand the importance of capturing the child's voice, with police referrals having an explicit section on the child's voice and commissioned services being required to demonstrate both how they record the young person's experience of the service they are receiving and how that service is seeking to learn from young people.

102. Participation and consultation with children looked after and care leavers are well established and effective. Children in care and care leavers have a voice and a central input into service development. In addition to this, they have representation on a number of forums, including the Corporate Parenting Panel and the Leaving Care Forum. Activities include delivery of training on children's rights, design of a new health passport, foster carer induction and training and involvement in recruitment of staff at all levels in the organisation. The members of the Children in Care Council report that they have been proactive in ensuring that all young people are aware of the availability of free leisure passes and that information about rights and responsibilities is included in the information packs that they have helped to redesign and that are given to all children newly looked after. There is active support to young people provided by two participation and inclusion officers to help ensure that their voice is heard. The local authority does not take the work of young people for granted. Those who offer their time to help the authority understand young people's concerns and work towards meeting their needs are appropriately remunerated.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is Good

Executive summary

The independent chair of Cheshire West and Chester Local Safeguarding Children Board (LSCB) has been successful and demonstrated strong leadership in engaging the local authority and partner agencies in the safeguarding agenda. As a result, she has ensured that all board members are ambitious in their drive to improve the effectiveness of the Board.

The LSCB fulfils its statutory requirements and with the support of a tenacious business manager and a range of effective subgroups, it has been instrumental in scrutinising and offering challenge where appropriate to its key partners in both the statutory and voluntary sector. As a result, the LSCB has achieved the recommendations from the 2012 Ofsted inspection of child protection services in relation to the monitoring and oversight of front-line practice.

The Board has a good clear governance framework and the recently updated protocols successfully ensure effective links between the Board, the Children's Trust, the Health and Wellbeing Board as well as the Adult Safeguarding Board and the Community Safety Partnership.

Key statutory areas are regularly and robustly scrutinised by the Board, including private fostering, allegations management, early help, missing and child sexual exploitation and the work of the Child Death Overview Panel (CDOP). More recently, the LSCB has made positive links with, and reported on the work of, the Local Family Justice Board (LFJB). Children looked after have been a clear focus and their views are well represented. The voices of children and young people from other vulnerable or diverse groups are less evident and therefore the Board does not have a cross-representation of children's views.

A comprehensive range of training is offered and receives positive feedback from professionals. Although the training and development group evaluates the effectiveness of specific training immediately after delivery, there is no overall consideration of the impact of the full training offer and the Board cannot be fully assured that the training provided is meeting the needs of all the professionals within the CWAC area.

The annual report for 2014–2015 effectively analyses the safeguarding work the board has undertaken in the last year, identifies progress against the key priorities and considers the effectiveness of the work undertaken by agencies.

The Board facilitates a comprehensive audit cycle in order to test the quality of front-

line practice. Historically, the quality of written outcomes of audits has not been consistently robust and the audits undertaken did not always provide an accurate reflection of practice at the front line. However, the case review group and the Board have made improvements that include allocating additional business support resources to support the process. A recent audit seen during this inspection was robust and more qualitative in its evaluation of practice.

The Board does not yet have a strategic oversight of female genital mutilation. Although prevalence is not high, the board recognise this as an area for development.

Recommendations

103. Continue to make improvement within the audit process so that the Board can further be assured that the findings are an accurate reflection of practice within CWAC (paragraph 120).

104. Further improve the contribution and engagement with young people so that the Board has an understanding of a broader range of views and can use these to influence the safeguarding agenda (paragraph 123).

105. Undertake a comprehensive evaluation of training along with the planned training needs analysis, and use this information to review the current offer to ensure that it meets the needs of all practitioners within CWAC (paragraph 116).

106. The LSCB should expedite the work in relation to female genital mutilation so that it can quickly analyse and report on the prevalence and hold agencies to account for their practice in protecting girls who are potentially at risk or who are at risk (paragraph 128).

Inspection findings – the Local Safeguarding Children Board

107. Since the last inspection of child protection services in 2012, the Cheshire West and Chester Safeguarding Children Board (the LSCB) under the leadership of the independent chair has progressed and implemented the identified recommendations in relation to the monitoring of safeguarding. Consequently, the Board can demonstrate effective delivery of outcomes, including a significant reduction in the use of overnight custody for young people.

108. The LSCB meets its statutory requirements as set out in the Children Act 2004 and the Local Safeguarding Children Regulations 2006. The Board has a

suitably experienced, independent chair who has a clear and ambitious vision for the LSCB. The Board benefits from the commitment and full support of a wide range of partner agencies represented at the right seniority, who commit resources to the board and to the safeguarding agenda.

109. The Board has a clear governance framework, which ensures cogent links between the LSCB and other strategic partnerships including the Children's Trust and the Health and Wellbeing Board as well as the Adult Safeguarding Board and the Community Safety Partnership. The work of these boards highlights an appropriate focus on safeguarding children and young people across the partnerships.

110. Regular reporting to the Board of key safeguarding areas including early help, private fostering, allegations management, child sexual exploitation and the work of the Child Death Overview Panel (CDOP) assists the Board in monitoring and evaluating the effectiveness of what is done by the local authority and its board partners, both individually and collectively, to safeguard and promote the welfare of children. Additionally, the LSCB has now made links with the Local Family Justice Board (LFJB) and the Board has received assurances that children's needs are a priority in relation to public and private law proceedings. Children looked after have been a clear focus for the Board and there was until recently a children looked after and care leaver subgroup. This subgroup now reports directly to the Children's Trust but oversight of its work will continue via regular reporting arrangements to ensure that safeguarding this vulnerable group continues to be a priority.

111. The chair of the Board meets quarterly with the Chief Executive, the DCS, the Lead Member for Children and the Leader of the Council and the minutes reflect challenge offered in relation to the work of the board and close monitoring of actions and plans.

112. The business planning process is highly effective and the 2015–2019 business plan has utilised information from the JSNA, audits and practice learning reviews (PLRs). The identified priorities are in line with local needs. The reporting system for the subgroups means that they hold responsibility for the work undertaken and report progress and exceptions to the board so that the board agenda remains focused on addressing the appropriate safeguarding areas.

113. The LSCB has high aspirations in relation to ensuring that Section 11 audits are meaningful and that the Board receives assurances that multi-agency partners are more than just compliant with safeguarding arrangements. The analysis of the most recent audit concluded that all agencies are meeting the required outcomes but, following challenge sessions, action plans are in place to assist the LSCB to consider more detailed evidence so that it can be confident that all agencies are ambitious in effectively discharging their safeguarding duty.

114. The board has secured an impressive three-year financial commitment from multi-agency partners to assist it in carrying out its statutory functions effectively. The level of contributions reflects the ethos that multi-agency partners see safeguarding as a priority.

115. The Learning and Improvement Framework is comprehensive and has been appropriately localised from the North West Learning and Improvement Framework to reflect the learning processes within CWAC. The LSCB works hard to ensure that the messages from reviews and audits are effectively disseminated and various creative dissemination methods such as newsletters, bulletins and bite-sized briefings were seen during the inspection

116. The Board offers a comprehensive range of training for professionals and front line workers with differing levels of need and the take-up of this is over 90%. Learning from reviews and audits influences and directs the training agenda and this year has included sessions on disguised compliance and a new assessment toolkit for front-line practitioners. The evaluation of individual training sessions demonstrates that it is well received by professionals and there has been some demonstrable improvements in key areas of front-line practice. In particular, pre-birth assessment training has led to a significant improvement in the quality of pre-birth assessments. There is no overall analysis of the impact of the full training offer. The Board therefore cannot be confident that it is addressing the practice needs of all professionals. In addition, there has been no evaluation of safeguarding training provided in individual agencies to ensure that it is fit for purpose. There are plans in place to address these shortfalls, including a training needs analysis and a new system for tracking impact.

117. The case review group makes timely and appropriate recommendations to initiate serious case reviews. The Board has undertaken and completed two serious case reviews (SCR) in 2015, within appropriate timeframes. Plans are in place to publish both the reports and continued efforts to engage the families in the process, including agreeing dates for publication, are evident. The LSCB has progressed the action plan of the first completed SCR prior to publication and the current work of the LSCB is focusing on expediting the learning. As a result, a review and refresh of the escalation process has been undertaken and the board has published assessment tools for all agencies.

118. The case review group uses the Practice Learning Review (PLR) process as an opportunity to learn from cases that do not progress to formal review, with four completed this year. All agencies can and do refer to the case review group when they consider that a case might meet the criteria for a PLR. The findings from these reviews are themed in order to aid action planning and learning. The case review group appropriately monitors and progresses the action plan. Where necessary, procedures and guidance are subject to reviews and updates. Bite-size learning events take place regularly to feed back themes as part of the learning cycle. The Board tests out the reach of the learning via audit, and LSCB visits to front-line services.

119. The comprehensive challenge log provides evidence of the Board holding partner agencies to account and tracking and escalating the outcomes where appropriate. The Board has provided strong challenge to partner agencies, leading to improvements in a number of areas, including police and youth detention arrangements and use of the graded care profile. A challenge in relation to schools completion of the Section 175 Audit resulted in a 99% compliance rate.

120. The LSCB has a realistic audit cycle led by the case review group. It has undertaken five multi-agency audits since January 2015, identified through issues and themes from PLR and SCR outcomes, previous audits, data analysis, or national and local issues. The quality of write-up of the audits, however, is variable and there have been deficits in the information provided. The board has recognised this and challenged the case review group, as it needs to assure itself that the audits undertaken are a true reflection of practice at the front line. The Board has taken action to address this shortfall, including allocating additional business support resources to the process and ensuring that there is consistency in the quality of reports. A recent audit seen during inspection was more robust and qualitative in its evaluation of practice.

121. The case review group recently undertook an unannounced audit of front door arrangements following the completion of a serious case review. The Board received assurances that decisions made about referrals at the front door are appropriate and effective and that the application of thresholds is consistent.

122. The Board has a three-tiered dataset, which is leading to more accessible performance information. It includes a comprehensive overview of data around child sexual exploitation. The dataset is analysed by the quality assurance group and exceptions reported to the Board and where appropriate this then becomes an area for development or challenge and scrutiny. In the last year, this has led to a multi-agency audit to look at an increase in admissions to hospital for self-harm, which was then a topic area for the LSCB conference. Although the dataset is primarily social care, multi-agency data are apparent and the board have challenged agencies about providing data when this has not been forthcoming.

123. Work on ensuring the voice of the child is implicit in the Board's work and is a recognised area for development, but the strategic co-ordination of this is not yet robust. There are examples of involvement of children and young people, including a conference run by and delivered to young people and children, and visiting a youth custody suite to offer input about ways to improve the environment.

124. The Pan Cheshire CDOP works effectively. The annual report and action plan is data-rich and identifies key themes and trends. The recently appointed chair has reviewed progress of actions from previous years and introduced an action log to ensure that findings and recommendations in individual cases are tracked and monitored. Actions are taken in relation to lessons learned both locally and

nationally including a safe sleep campaign and a challenge to hospitals to ensure swift notification to the CDOP of young people aged between 16 and 18 years old who die on adult wards.

125. There is an embedded Pan-Cheshire strategy in place for child sexual exploitation and missing children. The well-established and effective Pan Cheshire subgroup demonstrates a high level of understanding and commitment from all key partners in these areas of work. The work of this group influences and directs the CWAC child sexual exploitation subgroup and there is monitoring, both operationally and strategically of the work by all partner agencies. The board receives regular comprehensive reports which detail prevalence, work undertaken and planned strategic development. The board has been instrumental in the development of a dedicated multi-agency child sexual exploitation team. A recent evaluation of the service supported by the LSCB identified the need to extend the pilot so that its impact can be better analysed and to look at the potential integration of the service into the front door arrangements.

126. The recently refreshed LSCB website is accessible and easy to navigate around. It has a comprehensive, up-to-date set of procedures, which are interactive. The LSCB has a simple but effective threshold document in place, which is interactive and provides links to relevant procedures, documents and guidance for ease of use.

127. The annual report for 2014–2015 effectively analyses the safeguarding work the board has undertaken in the last year, identifies progress against the key priorities and considers the effectiveness of the work of agencies. The contribution of other agencies is clear but the document is very lengthy and diminishes the effectiveness of the report. The Children in Care Council rejected the proposal to develop a children's version of the report, as they believed that this would not be of interest to young people.

128. The strategic co-ordination of policy to address female genital mutilation is not yet developed. The Pan Cheshire protocol is in draft and the development of local practice guidance is currently work in progress. Training takes place but there is no understanding of how many professionals that this has reached yet. No children have yet been identified as victims or being at risk of FGM.

129. Although in its infancy, there is co-ordinated oversight of the 'Prevent' agenda. The strategic lead chairs the Channel Panels, and is knowledgeable about the agendas and links with the relevant partnerships, including the Community Safety Partnership, the LSCB and the Adult Safeguarding Board. The Channel Panel has met four times and has considered 30 cases with 12 referrals made since the panels commenced. The LSCB is aware of the prevalence and receives updates as part of its monitoring of safeguarding arrangements.

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 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 seven of Her Majesty's Inspectors (HMI) from Ofsted and one additional inspector.

The inspection team

Lead inspector: Sue Myers

Deputy lead inspector: Peter McEntee

Team inspectors: Shirley Bailey, Paula Thomson-Jones, Cath McEvoy, Russ Henry, Ali Mekki and Gary Lamb AI

Senior data analyst: Hywel Benbow

Quality assurance manager: Lynn Radley

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

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

If you would like a copy of this document in a different format, such as large print or Braille, please telephone 0300 123 4234, or email enquiries@ofsted.gov.uk.

To receive regular email alerts about new publications please visit our website and go to 'Subscribe'.

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