Cheshire East Unitary Authority

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: 6 to 30 July 2015

Report published: 15 September 2015

Children's services in Cheshire East require improvement to be good
There are no widespread or serious failures that create or leave children being harmed or at risk of harm. However, the authority is not yet delivering good protection and help for children, young people and families. The authority is not yet delivering good care for children and young people looked after. Leadership, management and governance require improvement as the characteristics of good leadership are not yet fully in place.

1. Children who need help and protection		Requires improvement
2. Children looked after and achieving permanence		Requires improvement
	2.1 Adoption performance	Good
	2.2 Experiences and progress of care leavers	Requires improvement
3. Leadership, management and governance		Requires improvement

[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 Inspection 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.

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The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates one children's home. This was judged to be good in its most recent Ofsted inspection.
- The previous inspection of the local authority's safeguarding arrangements/ arrangements for the protection of children was in April 2013. The local authority was judged to be inadequate.
- The previous inspection of the local authority's services for children looked after was in August 2011. The local authority was judged to be adequate.

Local leadership

- The interim Director of Children's Services has been in post since June 2015.
- The chair of the Local Safeguarding Children Board has been in post since June 2013.

Children living in this area

- Approximately 74,930 children and young people under the age of 18 years live in Cheshire East. This is 20% of the total population in the area.
- Approximately 12% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 10% (the national average is 17%)
  - in secondary schools is 7% (the national average is 15%).
- Children and young people from minority ethnic groups account for 5% of all children living in the area, compared with 22% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Mixed and Asian or Asian British.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 5% (the national average is 19%)
  - in secondary schools is 4% (the national average is 14%).

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

- The largest minority ethnic groups within the borough live in the two wards of Crewe Central and Crewe South.

Child protection in this area

- At 31 March 2015, 2,217 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 2,116 at 31 March 2014.
- At 31 March 2015, 308 children and young people were the subject of a child protection plan. This is an increase from 203 at 31 March 2014.
- At 31 March 2015, five or fewer children lived in a privately arranged fostering placement. Although the numbers are suppressed because they are low, the local authority's own figures indicate a reduction from the previous year.
- Since the last inspection, no serious incident notifications have been submitted to Ofsted and no serious case reviews have been completed or are on-going at the time of the inspection.

Children looked after in this area

- At 31 March 2015, 357 children are being looked after by the local authority (a rate of 48 per 10,000 children). This is an increase from 335 (45 per 10,000 children) at 31 March 2014. Of this number:
  - 137 (or 38%) live outside the local authority area
  - 29 live in residential children's homes, of whom 62% live out of the authority area
  - six live in residential special schools,[3] all of whom live out of the authority area
  - 266 live with foster families, of whom 36% live out of the authority area
  - 26 live with parents, of whom 31% live out of the authority area
  - fewer than five are unaccompanied asylum-seeking children.
- In the last 12 months to 31 March 2015:
  - there have been 21 adoptions
  - 19 children became subject of special guardianship orders
  - 127 children ceased to be looked after, of whom 7% subsequently returned to be looked after
  - eight children and young people ceased to be looked after and moved on to independent living

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

- three children and young people ceased to be looked after and are now living in houses of multiple occupation.

Executive summary

When Ofsted inspected children's services in Cheshire East in March 2013, children were receiving inadequate services that did not effectively help them, protect them or meet their needs. The Cheshire East Improvement Board (CEIB), established in June 2013, has worked successfully with local political and senior leaders, the Local Safeguarding Children Board and key partners to tackle the areas highlighted for improvement. Progress has been monitored by Ofsted in the intervening period. Leaders, managers and partners share a strong commitment and ambition for children and families to receive the best help and support. This is demonstrated by the strategic alignment of plans, political commitment to resources and the active involvement of young people in strategic decisions and plans.

The local authority embraces external scrutiny and challenge through peer reviews and multi-agency auditing, and is fully aware of areas of practice that still require improvement to be good. These include management oversight and challenge; improving consistency in the quality of practice and services for children and families; and continuing to improve workforce stability. Appropriate plans are being implemented to address these issues but variability in the quality of practice remains, and not all children receive timely services that meet their needs.

One of the CEIB's first tasks was to establish comprehensive and detailed performance information, which was swiftly achieved for children in need of help and protection. The CEIB established ambitious yet realistic benchmark standards at an early stage and these are now being used effectively to measure and drive improvement. Performance information for members and frontline managers, as well as local authority auditing, are not ensuring a sharp enough focus on children looked after. The new electronic recording system does not yet provide managers with all the performance information they need to ensure robust oversight. Some case recording is not sufficiently detailed to inform decision-making.

Some partners were slow to share accountability for the weaknesses in services for local children. The local authority has worked hard to ensure that all partners now take responsibility for the improvement of services for children and families. For example, health partners have taken a lead in revising the continuum of need for children, and the police have been instrumental in the effective co-location of partners within the Cheshire East Consultancy Service (ChECS). There is improved understanding and support from agencies, in particular schools, in providing children and families with early help. The strategic response to children who go missing or are at risk of child sexual exploitation is strong. Operationally there is more to do to ensure that social workers understand how best to use information from return home interviews to inform planning.

Multi-agency understanding of the threshold for services in Cheshire East is improving. Where children are at risk of significant harm, identification and referral to children's services for assessment, intervention and support is swift. There is more to do to ensure children and families receive timely early help when they do not meet the threshold for social work intervention and to embed understanding of the required levels of support for children and families when risks reduce.

Although support for children and families through multi-agency working is strong, there is more to do strategically to ensure that commissioning arrangements meet the needs of children in need of help and protection and children looked after. This is in relation to accommodation for care leavers, health provision for young people over the age of 16, initial health assessments, the provision of advocacy services for children in need and in understanding service need in relation to family group conferences.

Creating a stable and competent workforce has been a key challenge. The local authority has worked hard to improve recruitment and retention and to secure a sufficiently experienced and competent workforce. This inspection found improving stability, reduced caseloads for the majority of social workers and greater continuity for children. However, high turnover of staff has reduced the effectiveness of training, continual professional development and challenge through supervision over time. It has also hindered the embedding of statutory responsibilities in some key areas such as the timely identification, assessment and monitoring of private fostering and connected persons' arrangements.

Child protection chairs and independent reviewing officers have good oversight of individual cases but the impact of their challenge is not yet leading to consistently good services for children. This is particularly the case where there is historic drift and delay in taking decisive action to help and protect children and young people. The inspection found a lack of management grip in a small number of such cases, resulting in delays in improving children's circumstances. For other children and families, assessment and planning at all stages are not always as timely or as sharply focused as they should be. Recording of management decisions is inconsistent.

Planning for permanence is improving with a good focus on adoption. Considerable work has been done to ensure timely decisions for children are secured but some are still waiting too long for a permanent home. Support for adopters is a strength. There is more to do to help children understand their life stories and the reasons for decisions. Children looked after by foster carers are waiting too long for decisions to be made about their day-to-day lives because the local authority is not sufficiently clear about decisions that can be delegated to foster carers.

Recommendations

1. Strengthen senior managers' oversight and monitoring of:
   - complex cases where there are historic drift and delay in taking decisive action (paragraph 36)
   - private fostering and connected persons' arrangements to ensure that these arrangements are suitable and comply with regulations (paragraphs 40, 83)
   - care leavers who are homeless (paragraph 112).
2. Ensure the challenge provided by child protection chairs and independent reviewing officers addresses drift and improves planning for children (paragraphs 37, 84).
3. Ensure that supervision is reflective, challenging and consistently focuses on continual professional development (paragraphs 33, 130).
4. Ensure that where children do not meet the threshold for social work intervention their circumstances are considered promptly and they receive appropriate and timely early help (paragraph 25).
5. Ensure that strategy meetings and decisions are informed by relevant partner agencies (paragraph 27).
6. Improve the quality of recording so that all key discussions and decisions about children and their families, including management oversight, are clearly recorded (paragraphs 21, 23, 25, 33, 50, 55, 59, 86, 107).
7. Strengthen frontline practice to ensure effective action is taken to support children at risk of child sexual exploitation and those who go missing (paragraphs 41, 42, 58, 175).
8. Ensure assessments for children in need of help and protection and children looked after are timely, consistently consider the full range of children's needs, contain thorough analysis and are routinely updated to reflect changes in circumstances (paragraphs 29, 30, 51, 54, 59, 82, 98).
9. Ensure that plans to help children in need of help and protection, looked after children and care leavers, are specific, clear, outcome-focused and include timescales and contingencies so that families and professionals understand what needs to happen to improve circumstances for children. This includes improving the clarity of letters before proceedings so that the expectations of parents are clear (paragraphs 31, 32, 34, 36, 52, 55, 57, 65, 115).
10. Ensure that decisions to step down or close cases are appropriate and that management rationale to do so is clearly recorded (paragraph 39).

11. Improve the implementation of delegated authority so that carers are clear about what decisions they can make and children do not experience delays (paragraph 78).

12. Improve the timeliness of initial health assessments so that children who become looked after have their health needs assessed within the expected timescales (paragraph 67).

13. Ensure audit arrangements have a sharper focus on looked after children (paragraph 140).

14. Ensure that comprehensive and clear data and performance information are provided to managers and strategic leaders to enable them to better understand, oversee and scrutinise performance. This includes ensuring the accuracy of information provided through the electronic recording system so that managers have effective oversight of frontline practice (paragraph 137, 138).

15. Ensure that learning from complaints leads to clear action plans and that these are implemented, tracked and reviewed to inform and improve practice (paragraph 142).

16. Strengthen commissioning arrangements to ensure that services meet the needs of families and children in need of help and protection and children looked after by: (paragraph 150)

    - reviewing the use of foyer accommodation for 16–17 year olds
    - ensuring that rigorous risk assessments are undertaken before the placement of young people in foyer or hostel accommodation and review the practice of using this provision (paragraph 114)
    - ensuring sufficient health provision for older looked after children and care leavers (paragraphs 121, 124)
    - improving the use of family group conferences so that all possible options for children are consistently explored (paragraph 55)
    - increasing the capacity of advocacy services to support children and young people identified as in need (paragraphs 45, 85, 150).

17. Ensure later-in-life letters provide details of all known information, are written in plain English and are accessible to children so that they understand their stories (paragraph 107).

Summary for children and young people

- Senior leaders and managers in the local authority have worked hard to ensure that services to children and their families have improved a lot since the last inspection. Councillors and leaders have plans to make further improvements to ensure the best services for children.
- In the past children have had too many changes in social worker. This has recently improved. This means that social workers have been able to build better relationships with them. As a result of the increased time social workers now spend working with the same children and young people, they know them well. Social workers say they enjoy working in Cheshire East.
- When children, young people and their families need help it is usually available because a wide range of different professionals work well together to provide it. The right people, such as family support workers, school teachers and support staff, youth engagement officers and healthcare staff are well trained to understand what help is needed.
- Although children get the support they need, the assessment of their needs sometimes takes too long. Too many children wait too long before they get the right help.
- Looked after children, referred to as cared for children in Cheshire East, are well supported in the right placements, by foster carers and at school. Careful planning, progress monitoring and good use of the financial support available help the majority of children make at least the expected progress in their education.
- Care leavers benefit from close working relationships with their personal advisers who know them well and provide support that meets most of their needs. Plans are also being put in place to improve support, to encourage them to have high ambitions and to continue in education, employment and training.
- When care leavers have nowhere to live personal advisors do all that they can to help them find a safe place to live. However, senior managers do not understand enough about these young people's individual circumstances to ensure that the best support is provided to them.
- The adoption team are good at finding permanent families for children who can no longer live with their own families. Children are well supported in their new families. There are plans to improve the understanding children have of their life story.

The experiences and progress of children who need help and protection	Requires improvement

Since the last inspection there have been significant improvements in the quality of services provided to children in need of help and support, particularly in the identification and assessment of risk within families.

Early help for families is better coordinated. Partner agencies are taking a more active role in providing and coordinating early help and undertaking assessments of need. However, decisions about providing early help support to children who have been referred to children's social care are sometimes delayed. These children do not receive the right services to meet their needs early enough.

The local authority still has work to do to ensure consistent multi-agency involvement in assessments and plans, particularly in relation to their involvement in strategy meetings and in plans to support families when risk has reduced. Partnership working has considerably improved with schools, health and the police working well with the local authority to help protect and support children and young people.

Children in need of a social work assessment are identified and swiftly provided with appropriate levels of help through new arrangements by Cheshire East Consultancy Service. Assessments are completed in the timescales of the child and plans are reviewed regularly. However, the quality of assessments is not of a consistently good standard. They do not always reflect the needs, wishes and feelings of individual children.

Child protection and child in need plans are not always specific to individual children's needs or clear about what needs to change.

Not all frontline practitioners have had sufficient training and support to understand child sexual exploitation and missing from home issues to enable them to help the children with whom they work. The response to missing children and young people and those at risk of sexual exploitation is well coordinated and there are clear strategies in place to help these children and young people. However, not all return interviews are analysed fully.

The arrangements for case management of private fostering are not sufficiently robust.

Inspection findings

18. When children and families need early help and support, they can readily access a wide range of services that are effective in improving outcomes for children. The local authority uses 15 indicators to measure the impact of early help, including persistent absence from school, school readiness and family

relationships. Circumstances for these children and families have improved across all indicators in the past year. Early help and troubled families work are appropriately aligned. The local authority identified 585 eligible families in the first round of the Troubled Families Programme. After a slow start, all of these families are now being helped to make important changes leading to better outcomes for children.

19. At the time of the inspection, 871 children were being supported following a Common Assessment Framework (CAF) assessment, which was an increase from 658 six months earlier. A wide range of professionals complete CAF assessments, which reflects the training and awareness-raising that has been delivered. The most significant increase is from schools that take the lead role in coordinating increasing numbers of support packages for children in need of early help.

20. A large majority of CAF assessments seen by inspectors contain detailed records of need and clear plans of action to improve circumstances for children. However, not all record children's views. CAF plans are reviewed by lead professionals regularly and closed if sufficient progress has been made but the rationale for the decision is not always clearly recorded. This makes it harder to evaluate the effectiveness of the help received.

21. When improvements are not made or sustained through support from early help services, cases are escalated to children's social care for a child in need assessment and, where appropriate, social work support. In some cases the decision to undertake a child in need assessment should have been taken sooner.

22. Contacts from other agencies transfer swiftly via the Family Information Service to Cheshire East Consultancy Service (ChECS) where qualified social workers review and record them. All contact records show some evidence of workers considering the historical information available to inform their decision-making. This is not always recorded in as much detail as required to inform next steps and this results in practice managers requesting further information and to some delays in decision-making.

23. Where contact information clearly meets the threshold for social work intervention, social workers identify this well and quickly pass completed contact records to practice managers who then transfer cases immediately to the locality team. Once children transfer to the locality team they receive a timely and appropriate response that reflects the nature of the information received in the form of visits, implementation of child protection procedures and allocation for assessment and support.

24. Where contacts require further consideration before decisions are made there is evidence of delays in information gathering and decision-making. As a result some contacts seen were open to social workers for periods of up to 10 days without decisions being made, often without evidence of sufficient oversight by

practice managers. While none of these children are at immediate risk there are a small number who could receive help earlier with more prompt decision-making. Consent for information-sharing is consistently considered but in some cases records are not clear as to why the decision is made to proceed without consent.

25. Where the threshold for social work assessment is not met children are signposted to receive early help services by way of a common assessment led by partner agencies or by Cheshire East Family Service (CEFS) staff.

26. Where children are at risk of harm, strategy discussions take place to determine whether section 47 enquiries are required. In the majority of cases seen these are initial telephone discussions between a practice manager and the police, without the involvement of other agencies such as health. This means that these decisions do not consistently take account of all relevant information. Managers have identified that working practices between social work teams and the police need to develop further to improve the quality of information-sharing and include the involvement of other agencies. Child protection thresholds are applied appropriately and where appropriate new plans are made with an emphasis on reducing risk. In the cases seen during inspection, children at risk of harm were seen in appropriate timescales, within 24 hours. However, an audit carried out in July 2015 by practice managers found that this is a fluctuating area of performance that still requires improvement.

27. Cheshire East Emergency Duty Team (EDT) provides a good service for children and adults who require social work intervention out of hours. This is a dedicated team of experienced social workers and support staff with oversight from a team manager. In addition all EDT staff access telephone advice and support from children's social care managers who are available at all times through a rota.

28. Timeliness of assessments is good with timescales appropriate to the needs of the child. Not all assessments are of sufficient quality, particularly in demonstrating that risk to children from domestic abuse, parental mental health or substance misuse are fully considered and understood. Adult social care is not routinely involved in assessments of children where these factors are present. The specific needs of children within the family are not always differentiated, and this leads to conclusions and plans that do not take account of individual children's experiences.

29. Issues of diversity and cultural needs are not consistently well explored and responded to in all cases. Assessments do not fully explore issues of race and gender and how they impact on children's experiences within their own family. However, examples were seen of social workers sensitively responding to and supporting gay young people. Children's views and ideas are included in assessments and recorded on case files. Social workers see children regularly and speak warmly about them but there is little evidence that they explain to them why decisions have been made or help them to understand their

circumstances better. Some children have their own family support worker which helps them to explore their thoughts and feelings and some purposeful direct work was seen in these cases. There is evidence on case files of parents being involved and consulted during assessments, but some parents spoken to say that they do not always feel listened to.

30. Child protection and child in need plans are not always specific to individual children. They lack timescales and contingency planning. Casework is not consistently underpinned by theoretical models or a full understanding of whether changes in children's circumstances are sustainable. Direct work with children in some cases is not informed by the assessment or plan and consequently lacks focus.

31. Social workers are too slow to respond to lack of progress on some children's plans and not all partners are as involved in planning as others. Schools are a strong partner and support vulnerable children with a good range of services including play therapy and family support. Adult service social workers and housing providers are less involved and plans do not always reflect a coordinated multi-agency response to children's needs. This means that children do not always receive services that meet their holistic needs. Case records are generally up-to-date but the quality is not consistently good. Some are too brief and lack detail of children's experiences and progress made on plans. This results in a minority of cases being closed too soon because the complexities are not fully recorded or understood. Chronologies are not used regularly to map significant events in children's lives. Important historical information that impacts on children is not sufficiently analysed to inform decision-making and planning.

32. Social workers feel supported by practice managers and supervision is frequent, but they cannot describe how their practice is monitored or challenged through the supervision process. Practice managers' oversight of casework is not clear in most of the cases seen and there is little evidence of direction, challenge or support where plans for children have not progressed or work has not been completed in a timely way. There is evidence of auditing activity on case files and social workers generally comply with actions arising from the auditing process. There has been a high turnover of staff, which has made it difficult to establish practice standards and create consistency. This is now improving as the workforce becomes more stable.

33. Thresholds are published by the Cheshire East Safeguarding Children Board (CESCB) and shared with partner agencies. CESCB training to reinforce the shared understanding is well attended and there are agreed systems for moving cases across the threshold of need. In practice, the application of thresholds remains inconsistent. Cases stepping up from child in need to child protection are identified and action is taken to put child protection arrangements in place but sometimes this has taken too long and children have been without a clearly focused child protection plan. The local authority has recognised this and has

made very recent improvements. Two reviewing officers are being recruited to oversee and escalate such cases more promptly.

34. There has been a significant increase in the number of children subject to a child protection plan over the past 12 months. In March 2014 there were 203 children with a protection plan, rising to 308 in March 2015. This 2015 figure is a rate of 41 and is closer to the England rate of 42 per 10,000 children. The rise is due in part to a greater focus on children who are at risk of being sexually exploited, reflected in the increase in children who are subject to a child protection plan under the category of sexual abuse.

35. Around 10% of all children subject to child protection plans have been on a plan for more than 15 months. This group of 28 children includes two large sibling groups. A sample of these cases shows drift and delay in making progress on plans and improving circumstances for children. The graded care profile is not being well used to assess cases of neglect, which make up 49% of children on plans. Inspectors saw cases where historical neglect within families is still affecting children's lives because change is difficult to sustain. Managers have not provided enough oversight of these cases to ensure plans are clear and effectively progressed over time. Child protection review conferences are not consistently held within timescale, with 11% taking place later than planned according to the local authority's own figures. Reviewing officers see children before and after conferences to gain their views and to explain decisions made at the conference. There is no formal tracking, recording or reporting of the numbers of children and young people seen but management information reports that 93% of children and young people participate in some way in their reviews.

36. Conference chairs raise practice alerts if they see lack of progress or poor social work practice. These alerts almost always result in action being taken and reviewing officers will check that alerts have been responded to. A spreadsheet of alerts is kept to monitor progress and this is sent to the head of service who uses them in fortnightly practice challenge meetings. Reviewing officers also issue good practice alerts where appropriate. This is recent practice and is not yet demonstrating sufficient impact for children, although practice challenge meetings are contributing to raising standards.

37. Conferences are well attended but the local authority's capacity to monitor the contribution of other agencies is reduced because the electronic recording system is not yet fully functional. This also applies to parental attendance, currently recorded at 42%, but in fact higher.

38. Inspectors saw a number of cases that had been closed to children's social care and stepped down too soon, with too little progress made, and change not sustained to secure improved outcomes. In these cases social workers are over-optimistic about the progress families can make. Some cases are stepped down for management at CAF level before all of the actions in the child in need plan have been completed and when families clearly still need support and

monitoring. The local authority has recognised through its auditing process that too many cases are being stepped down too soon and has recently issued a direction to practice managers to ensure greater oversight and consistency of practice.

39. The number of private fostering notifications remains low. This is in keeping with national challenges inherent in identifying such arrangements. Cheshire East has taken steps to raise awareness and understanding with frontline staff, other agencies and members of the public. For example, the authority has recognised that the term 'private fostering' might be confusing to the public and has recently changed its posters and leaflets to address this. Case oversight has recently been strengthened by the allocation of an independent reviewing officer to oversee current cases to ensure statutory compliance. However, three cases sampled showed delays in responding to notifications, Disclosure and Barring Service (DBS) checks, visits and decision-making. There is no evidence of management oversight identifying or challenging these delays. The draft action plan in place to address these issues is outcome-focused with clear priorities. However, it lacks timescales for actions to be completed, which reduces its effectiveness.

40. The local authority and its partners take seriously their duties and responsibilities to those children who go missing from home or care and have worked well together to establish clear strategies and protocols to help these children. In the last year there were 243 instances of young people going missing, pertaining to 115 children. Seven young people went missing from care more than five times and three young people went missing from home more than five times. All have a detailed support plan in place and a named social worker responsible for the plan. Return interviews are provided by a commissioned service and copies of these are sent to social workers and the police. Not all social workers use information from these interviews to inform on-going work with young people or to explore wider issues such as links with other missing young people. This reduces the impact of the strong strategic arrangements in place.

41. There is a clear connection between arrangements for children who go missing and those for children at risk of child sexual exploitation. Children who go missing are consistently assessed against recognised tools for risk of sexual exploitation. Professionals across Cheshire are using intelligence successfully to identify and disrupt perpetrators. However, case files and observations of meetings show that while tools and checklists are being used, there is a lack of skilled, sensitive work with children and young people to understand individual vulnerability and risk. Some social workers spoken to said that they had not had training in child sexual exploitation. In part this is due to the high turnover of staff. Training continues to be delivered periodically, with increasing impact on consistency in practice as the workforce becomes more stable.

42. Children missing from education are carefully monitored. Managers receive prompt notifications from schools and then carry out appropriate checks with a

wide range of relevant agencies. The 90 children who are on flexible timetables, including alternative provision, are known and monitored. Around two thirds are not receiving 25 hours every week and this is mainly for medical reasons. There were 1,629 fixed-term exclusions from secondary schools and 257 from primary schools in 2014/15. Of 23 permanently excluded children 22 went directly to the pupil referral unit and one primary child went to an alternative school.

43. Children and young people who are electively home educated (EHE) and their carers are given appropriate advice and support through the oversight of a manager who has developed good relationships with schools, parents and the EHE community. There has been an increase from 150 in September 2014 to 215 currently known to be EHE. A small minority of these are known to social care. Helpful advice and guidance are provided to parents and 30 cases resulted in parents returning their children to mainstream education; this includes young people who were experiencing unsuitable education. Home visits are carried out by the EHE manager and letters are sent to encourage parents to accept advice and guidance at home.

44. Advocacy is offered to all children subject to a child protection plan through a commissioned provider. The advocacy service is well publicised and take-up of the service is increasing. Evidence from a recent small-scale pilot supporting young people to attend their child protection conference is encouraging. Not all children in need are offered advocacy and this is a gap. Advocacy is offered to those children who are at risk of sexual exploitation but are not subject to a child protection plan. There are no plans to change the arrangements for the delivery of this commissioned service.

45. The local authority has a good understanding of the prevalence of domestic abuse, adult mental health and substance misuse. Substance misuse was recorded as a factor in 7% of assessments; combined with alcohol misuse, this increased to 15%. Currently 357 children are living with substance misusing parents, of whom 14 are subject to CAF, 46 are children in need, 26 have child protection plans and one is subject to a child sexual exploitation plan. An appropriate range of services are commissioned to support families. Parental mental health problems were recorded in 9% of assessments. The local authority is working with adult services to achieve greater integration at the front door when parents are access adult services. Domestic violence was recorded as a factor in 22% of assessments (2013–14 child in need census).

46. Responses to domestic abuse are improving, and the co-location of the domestic abuse hub with ChECS has helped to improve shared working practices. Vulnerable persons alerts (VPAs) are screened by the police and where children may be at risk or in need these are forwarded to ChECS. The co-location of police with ChECS is helpful in making these decisions, although inspectors saw cases where the police had taken too long to forward alerts to children's social care. All VPAs are forwarded to the domestic abuse hub and victims who request or require a service are appropriately helped. Currently

there is no information available to report on the proportion of children in need and children subject to a child protection plan who are supported by the hub. This means that the local authority cannot fully evaluate the effectiveness of this provision. The service reports that it received around 400 referrals in the past 12 months, and around 65% of these families are engaged with the service. Multi-agency risk assessment conferences (MARAC) are well attended; agencies share information in advance and follow up any actions from panels. This year 484 adults were referred to MARAC with 636 children, a rise from the previous year of 357 adults with 455 children. The analysis of this by service managers indicates earlier identification and effective support for families experiencing domestic abuse.

47. When concerns are raised about individuals who are in a position of trust in relation to children, arrangements are clear and consistent. Appropriate referrals are made by a range of agencies to the designated officer. A sample of these cases showed appropriate and prompt responses. Training is provided to agencies on safer recruitment and safe behaviour and the designated officer offers consultations before formal referrals are made. This has resulted in a reduction in the number of unsubstantiated cases as agencies get better at identifying risk to children.

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

Too few children have comprehensive, up-to-date assessments that give a rounded picture of needs and inform planning. This means that in many cases plans do not always reflect or address current circumstances and needs. Some plans have a lack of focus on desired outcomes. Work undertaken with families before they enter legal proceedings is tracked but not clearly recorded. In a small number of cases it was not clear if more could have been done to prevent children becoming looked after. Support services for children on the edge of care are effective.

When children go missing from care, return home interviews are not consistently carried out. Where return home interviews take place the information recorded is not comprehensive. There are some delays in return home interview records being sent to social workers.

Support for the education of children looked after is positive and their progress is good at Key Stage 2 and improving at Key Stage 4. The virtual school carefully monitors this provision. Most children looked after have had an assessment of their health needs, but there are delays in some initial health assessments taking place. Review health assessments are timely.

The children in care council is helping the local authority to improve services. Despite this, examples of its influence are mostly recent and some have taken a long time to achieve.

Although adoption performance is positive and there is increasing and appropriate use of special guardianship orders (SGOs), permanence is not achieved for all children sufficiently quickly. Children with adoption plans are now matched with adopters in a timely manner. The local authority has effective collaborative arrangements for recruiting and training adopters and has more than sufficient numbers of adopters for children, leading to appropriate matching. The quality of adoption reports is good. Post-adoption support services for adopters and special guardians are a strong feature. Plans to achieve a 'gold standard' service for care leavers have not yet resulted in consistently improved outcomes and the quality of practice remains too variable.

Senior managers do not have sufficient oversight of care leavers who are homeless. Risk assessments on young people living in foyer accommodation do not take into account any additional risk due to the setting and are not routinely completed on care leavers. Almost all care leavers remain looked after until they reach 18 years of age. They benefit from close supportive working relationships with personal advisers who know them well. A revised 'staying put' policy was issued in April 2015 but it is too early to evaluate. Pathway plans, while improving, are not clear enough about what needs to happen and managerial oversight is not always focused on progress against the plan. Financial support to young people setting up home or at university is good. The percentage of care leavers in education, employment and training improvement is higher than in comparable local authorities.

Inspection findings

48. At the time of the inspection there were 387 children in the care of the local authority. This is a rise from the 335 reported in March 2014 but is lower than previous years.

49. The local authority has a range of services that can support children at risk of becoming looked after. These include the @CT team and the Multi-Systemic Therapy (MST) service. The @CT team provides intensive support for children aged 10–18. It has worked with 132 children since it started in July 2014, of whom only 11 have subsequently become looked after. The MST service works with young people aged 11–17. Of approximately 40 young people worked with, only two have become looked after. Long-term follow-up at six, 12 and 18 months demonstrates the effectiveness of this work.

50. Decisions for children to become looked after are appropriate in the majority of cases. In other cases further work may have prevented children becoming looked after, but recording is not clear enough to evaluate this effectively. Examples were seen of delays, such as in seeking legal advice.

51. In too many children's cases, assessments are not up-to-date and are not sufficiently thorough or analytical to present a rounded, contemporary picture of children's needs. They can be too narrowly focused on what the social worker perceives to be the presenting problem, and therefore do not consider the full range of issues. Other assessments are out of date. Even recent assessments are not consistently updated in relation to significant events.

52. Too few looked after children have good quality care plans. Plans do not always reflect or address current circumstances and needs, while some lack drive towards desired outcomes.

53. Inspectors saw examples of effective multi-agency working, with a range of professionals involved in the development of care plans, health assessments and personal education plans. When children return home from care an update to the assessment is not always undertaken to inform this decision and identify appropriate levels of support needed. In one child's case, a failure to assess a return home adequately led to a swift return to care.

54. Children's cases subject to the pre-proceedings phase of the Public Law Outline are tracked but the work done is poorly recorded. Only a few records showed that families had letters setting out the concerns, though some files recorded parents being provided with these. Example letters seen listed concerns but were not clear about the impact of these on children, and the actions expected of parents were insufficiently clear and lacked timescales. This could mean that parents do not know what is expected of them. Managers report that family group conferencing is not used well and its impact is unknown.

55. Decisions to enter proceedings or pre-proceedings are appropriately made through legal advice meetings. These meetings are appropriately chaired by group managers. The Children and Family Court Advisory and Support Service (Cafcass) reported that the work presented to courts is of variable quality. This is acknowledged by the local authority and managers are aware of training needs.

56. Permanence is not consistently well prioritised. Examples were seen where children have achieved permanence within timescales appropriate to their needs, or where delays in achieving permanence have been minimised through effective contingency planning and swift responses to difficulties. However, some children have experienced delays in permanence plans being developed or progressed quickly enough, particularly where their needs have been poorly assessed.

57. Although the numbers of children going missing from care are tracked and data demonstrates a reduction in missing episodes for some children over time, the response to children going missing from care is variable. Where return home interviews take place the information recorded is not comprehensive. There are delays in return home interview records being sent to social workers. Information from missing interviews is not used consistently by social workers in planning for children. Links are made between children going missing and the possibility of child sexual exploitation. Not all social workers have received sufficient training about issues relating to children going missing or being at risk of sexual exploitation. However, inspectors saw examples of effective work with children at risk of sexual exploitation. The local authority has taken recent and positive action to increase resources to undertake return home interviews through its commissioning arrangements.

58. Most looked after children are visited regularly by their social workers and some describe positive relationships with them. Children feel confident about talking to their social workers about difficulties and say that these discussions lead to actions that make things better. They feel welcome and at home in their placements. They understand what the plans are for them, feel consulted about these and feel that their views are listened to. All children and young people spoken to feel supported to pursue their hobbies and interests. Children have contact with the people who are important to them, and say that they value this. Contact is regularly considered at their looked after reviews, though the recording is not always sufficiently detailed to show the benefits to the child of the contact. In some cases seen, contact had not always been subject to a rigorous risk assessment, though no children were found to be having unsafe contact during the inspection.

59. At the time of the inspection only five (3%) of looked after children aged 10 or older who had been looked after for a year or more were known to the youth offending service. This compares well with the most recent national figure from 2013–14 of 6%, and is an improvement on the local authority's 2014–15 figure of 9%. However, current reporting systems do not allow detailed analysis of

patterns of offending in order to better target preventive action. Collaborative working between youth justice workers and children's social care is mixed. In some cases good collaboration helped young people reduce their offending behaviour. In other cases less progress was made.

60. The Head of the Virtual School (HVS) is supported by a well-trained team. Schools feel supported and challenged by the virtual school team in their efforts to help looked after children to make at least expected progress. Well-targeted use of the pupil premium and additional funding helps children improve their progress and attainment. A range of additional activities are also provided for looked after children in their leisure time, such as holiday clubs, football clubs, horse-riding and music.

61. Not all looked after children attend good schools. Around 13% of the 294 children aged 4–16 are in less than good schools but they are well supported and their performance is closely monitored. The virtual school team also carefully monitors all the alternative provision provided by schools. Most of this is for young people at Key Stage 4 and is at registered vocational training providers. Where appropriate the virtual school team ensures children return to mainstream education as soon as possible. The children and young people being educated outside Cheshire East in adjoining authorities benefit from additional support and progress monitoring.

62. The average attendance of cared for children was 93% in 2013/14, which is below the virtual school target of 95%. All those failing to achieve this target are closely monitored by schools and the virtual school team. Of these children, 6% are persistent absentees, which is slightly higher than the figure for England. Plans are in place, but not yet implemented, to send letters to carers regularly to remind them of the importance of full attendance.

63. The HVS closely monitors the progress and attainment of looked after for children and has accurately assessed their performance at the key stages of education. Overall the significant attainment gap between looked after children and all children is closing. At Key Stage 1, the progress of most looked after children in reading, writing and mathematics requires improvement. At Key Stage 2 their progress is good, being significantly better than national comparators. From Key Stage 2 to Key Stage 4 the numbers making two levels of progress are below national levels, but the proportion gaining at least 5 GCSEs at grades A* to C, including English and mathematics, has increased over the last three years from 6% in 2012 to 15% in 2014.

64. All looked after children have a current personal education plan (PEP) and the quality of these has improved as a result of careful monitoring and training provided by the HVS and her team. Members of the virtual school team attend all initial PEP meetings and, following risk assessment, most follow-on PEP meetings. Records of progress and achievement against improvement targets are appropriately completed by teachers who have been trained for this role. As a result, most capture appropriate levels of detail and the child's voice using

age-specific documents. However, the level of detail in two out of the 10 PEPs sampled was insufficient and the preciseness of the targets to be achieved to improve performance was variable.

65. The virtual school carefully tracks the destinations of Year 11 pupils so that they can support their onward progress. Cheshire East data shows that, in September 2014, 92% of these looked after young people continued in education or secured training or employment, which is an improvement from 89% in the previous year. There is, however, a significant drop-out rate. By June 2015, 76% remained in education, employment or training (EET), although this is still higher than the latest figures for England as a whole. Work is already underway, through a 16-plus education, employment and destinations group, to improve the proportion of young people who sustain themselves in EET as they progress towards becoming successful care leavers, although it is too soon to judge the impact of this work.

66. Strength and difficulties questionnaires are used well to inform the work undertaken to improve the emotional health and well-being of children. There is improved performance in their completion and quality. For the year 2014–15, 134 of the 138 children who remained in care for more than 20 days had an initial health assessment. However, only 41 of 138 were completed within the expected timescale (30%). In the first quarter of 2015–16 this improved slightly to 36% but this still represents poor performance. The local authority is taking steps to strengthen arrangements by introducing an early alert system to improve response times. Performance for review health assessments is significantly better. Health data for 2014–15 demonstrate good performance. Almost all (98%) looked after children are up-to-date with their immunisations, have had a dental check and an annual health assessment. Young people feel their health needs are supported well.

67. Young people receive a wide range of support for emerging mental health needs from child and adolescent mental health services (CAMHS) and trained practitioners in the dedicated health team for looked after children. They are seen within one week of referral by this service. Facilities for therapeutic work, including play therapy and art therapy, are good. Foster carers are provided with timely advice which in some cases is reducing risk of placement breakdown. When children need mental health interventions at tiers three or four, waiting times range from three to 11 weeks depending on where the service is based and its specialism. Looked after children referred by the looked after children's health team are given priority but actual waiting times were not distinguishable from other children. However, in cases sampled children were offered timely support leading to improved outcomes.

68. Placements are good for many children, meet their needs and have a positive impact on them. The local authority only places children in homes that are good or better and monitoring of these arrangements is robust. Most children are placed within 20 miles of home, with 16% placed further away than this.

Brothers and sisters are placed together in most cases. Children are not disadvantaged by living out of area.

69. Overall, children do not move more often that they need to. At the end of March 2015, 8% of looked after children had three or more placements in the previous year. This is an improvement on 14% the previous year and lower than the England level of 11% for 2014. Similarly, 65% of those who have been looked after for more than two and a half years at the end of March 2015 had been in the same placement for more than two years. This is similar to the previous year and the levels seen by comparators.

70. A review of the fostering service was undertaken in 2014 in recognition of the fact that it was unable to meet the demand for foster homes. Subsequently, timescales for completion of fostering assessments have improved, as have fostering bed occupancy rates. At the time of the inspection 129 children were being cared for by their long-term foster carers and 28 children were waiting to be matched with long-term carers.

71. At the time of the inspection, the local authority had 109 mainstream foster carers (202 beds), seven short break carers (nine beds) and 27 family and friend foster carers (39 beds). It has a target of approving 35 new households during 2015–16, particularly for sibling groups and mother and baby placements.

72. The local authority recruited 21 new fostering households but only managed a net gain of six during 2014–15. As of 31 March 2015, 75% of Cheshire East's looked after children were being cared for by foster carers, of whom 56% were in-house carers. Family and friend foster carers provide care for 18%. Of the remaining children in foster care, 26% are with independent foster carers; 57% of these are within 20 miles of their original homes.

73. The quality of fostering assessments is good, clearly evidencing strengths and vulnerabilities of carers. All annual reviews are presented at panel which are now reviewed by independent reviewing officers. This is a change from last year when they were completed by a fostering team manager, and now allows for independent scrutiny. Feedback from children's social workers is not included in the reviews universally, but has improved since being raised with managers.

74. The fostering service runs a successful and effective scheme, which awards grants to extend or adapt homes or buy new cars to meet the needs of children within fostering households. When current projects are complete the scheme will have helped improve the lives of about 20 children, including enabling sibling groups to remain together.

75. Foster carers receive good training, although they do not like the e-learning offer. The take-up of training is good, with 83% (local authority's own data) of foster carers having completed the training, support and development

standards training, compared with 78% as of March 2014. This was 21% higher than the England average.

76. All foster carers spoken with are aware of the delegated decision-making process, but feel social workers still have to complete too many forms. For example, if a foster carer agrees that a child can go to another carer for an overnight stay, forms still have to be completed, rather than the foster carer having the discretion to decide.

77. Relevant paperwork about children's background and needs are not always provided to foster carers at an early enough point – before or at the point of a child being placed. Two foster carers stated that, when a child was placed with them in an emergency, they had experienced a delay – in one case of two weeks – causing undue pressure on their family as they were unfamiliar with the child's background or how best to support the child.

78. Some foster carers feel that communication with the service could be better. They talked to inspectors about not being told about contact plans being changed, and not being informed about long-term plans for a child in their care.

79. Foster carers spoken with described very positive relationships with their individual workers allowing for trusting relationships to be established to support children in their care. However, some have experienced delays in visits from their supervising social workers, due to the team experiencing sickness and vacancies. This is acknowledged by the service and plans are in place to address this.

80. Where looked after children live with relatives or friends, assessment of these connected persons is not always sufficiently robust. In the main, assessments look at the areas required to ensure children are safe. However, the timescales for the completion are not always adhered to, and it is not clear in all cases that the assessments are signed off by senior managers.

81. In a large majority of cases children have positive experiences of their reviews. Their wishes and feelings are made known through consultation processes, observations and by attending. Most children spoken to knew their independent reviewing officer and felt that they listened to them and ensured their views were represented at reviews.

82. The caseloads of independent reviewing officers are between 70 and 80 children. Evidence was seen in some cases of independent reviewing officers undertaking mid-point reviews on the progress of plans. Independent reviewing officers raise concerns through the dispute resolution process, but as yet this is not having sufficient impact on the overall quality of assessment and planning for children looked after.

83. Advocacy is offered to all looked after children. Those placed at a distance are not disadvantaged and receive the same level of service as children living more

locally. Advocacy services are well publicised and take-up by looked after children is good. Take-up of independent visitors is low. Despite this there is a current waiting list of 10 young people. Some are waiting for volunteers who fit the profile that the young person wants and three are waiting because of difficulties in recruiting volunteers who are able to travel to young people placed at a distance. One of these young people has been waiting for nine months. Plans are in place to address both these issues but in the meantime some of these vulnerable cared for children are waiting too long.

84. Key discussions and decisions are not fully recorded on the child's case record. This makes it difficult to follow the child's story and could mean that important information is missed by, for example, a worker new to the case. It will also make it difficult for children who wish to view their records in the future to understand why and how key decisions were made.

85. The children in care council is positively engaged and helping the local authority to improve services for looked after children. There are recent examples of their influence effecting change. However, despite their input some changes have taken a long time to achieve, such as the development of a care pack for children entering care and refreshing the pledge for children looked after.

86. Diversity issues are not always considered well. Some children's case files have very little evidence of consideration of diversity, while in others needs in relation to diversity are recognised but poorly explored or poorly responded to. In better cases, appropriate consideration is given to diversity needs arising from culture, mental health difficulties and special educational needs, with some positive examples also seen of consideration of children's diversity needs arising from experiences such as neglect.

The graded judgment for adoption performance is that it is good

87. Adoption is an active permanence option for all children who are unable to return to their birth families. The local authority is part of a formal collaboration, Four4Adoption, working with three neighbouring adoption services and thereby expanding its reach and capacity for information evenings, recruitment activity and support to adopters. This leads to a broader pool of adopters to meet the needs of children with adoption plans. The local authority increased the number of adopters recruited during 2013–14, seeing an increase by 72% and a further 29% increase during 2014–15 (nine additional adopters recruited).

88. The service has invested in additional staff and support to adopters and special guardians through use of the adoption reform grant and funds received through inter-agency fees, received when Cheshire East adopters have children placed by other local authorities. This is resulting in effective family-finding for children and support to adopters and special guardians.

89. The local authority is now targeting its recruitment on adopters for sibling groups and children with complex needs to reflect the number of such children with adoption plans. At the time of the inspection, the local authority had 28 children with an adoption plan, with nine children placed with an adoptive family, a further seven matched and seven awaiting placement orders. This leaves five children in two sibling groups waiting. In each case there are complicating factors contributing to the delays.

90. The local authority's three-year average adoption scorecard performance for 2011–14 shows variable performance. For this period the time taken to decide on a match with an adoptive family – at 208 days – was less than the England average but slightly longer than comparators. However, the average time between a child entering care and moving in with its adoptive family – at 747 – days was significantly longer than for comparators.

91. However, closer analysis of the local authority's adoption data and performance demonstrates that more recent practice is effective, with timely adoptions of children and, significantly, an improving trajectory. The local authority has pursued adoption as the right permanence option for children and understands its performance. For example, from 2012 the average time between a child entering care and being adopted is 353 days (unpublished data), much less than the national average of 628 days. Similarly, during this period it took on average 140 days from deciding on a match to a child moving in with his or her adoptive family. This demonstrates good performance for the past three years.

92. Age and ethnicity are not a barrier to achieving permanence through adoption. The latest adoption scorecard shows that the local authority had a higher number of children (16%) exiting care through adoption than the England average (14%) and also in comparison with statistical neighbours (14%). The local authority succeeded in achieving adoption for 6% of children over the age of five years, which is 1% above the England average for 2011–14; and for 17% of minority ethnic children, which is 9% higher than the England average and 10% better than its statistical neighbours. Of the children adopted during 2014–15, 19% were aged over five years, further evidencing good performance.

93. The local authority's timescales for concluding care proceedings are good, enabling children to be matched and placed with their adopters in a timely manner. The latest available data shows the local authority's average time for concluding care proceedings is 25 weeks, better than comparators by four weeks and the England level by five weeks. This is an indication of the positive work undertaken regionally with Cafcass and the courts. No children have had their adoption plan changed during 2014–15. During 2015–16, two children have had their care plans changed due to the court not making a placement order. Permanence for children is also considered through options other than adoption to provide children with stability and security. The local authority had 19 children leave care through the making of special guardianship orders (SGOs), which is 15% of the children who left care during 2014–15. This is

positive, but a slight decrease on 2013–14, when 17% of looked after children exited care due to an SGO. It is still better performance than comparators by 2% and higher than the England average by 6%. The local authority's SGO carers can access the full range of support available to adopters, which improves children's chances of experiencing stability into adulthood.

94. At the time of the inspection the local authority had 14 adopters awaiting placements. The longest wait had been since September 2014. This demonstrates sufficient numbers of adopters for children requiring adoptive families. In almost all cases where adopters are not matched to local children they are referred to the national adoption register or considered by the Four4Adoption collaboration or the regional consortium.

95. The local authority recruited 40 adopters during 2014–15, which is an increase of nine on the previous year. Timescales for the two-stage recruitment process are improving. Adopters spoken with stated they had received a timely and positive response to their initial enquiry, which contributed to them deciding to apply to Cheshire East. The local authority has held a recruitment event to promote fostering to adopt and presently has three carers, but is yet to place children with them due to matching profiles. Fostering to adopt is actively promoted to adopters and social workers in the child care teams to help them understand how it benefits children.

96. The adoption service home-finding social workers have been solely focused on family-finding activities for children during the last six months and this is now resulting in timely adoption placements being achieved. These workers track children effectively from the point of pre-proceedings. The local authority profiles children well through a range of means including DVDs, an online resource (Adoption Link), exchange days, Four4Adoption collaboration and the regional consortium. This helps ensure that permanence through adoption is achieved in a timely manner.

97. The local authority's adoption panel is chaired by an experienced person with relevant experience and the panel operates effectively. It has a strong stable membership, but recognises it would benefit from being more diverse and recent recruitment to the panel will address this issue. Panel members probe thoroughly issues identified in reports and have deferred a case where there were inconsistencies in the report. All panel members have up-to-date appraisals, as does the chairperson. Appropriate challenge by the panel chair is well-evidenced in six-monthly quality assurance reports.

98. The ethnic profile of Cheshire East's adopters reflects the looked after population. The adoption service has recruited same sex couples and single male and female adopters. During 2014–15, three sets of brothers and sisters were adopted together and no children were adopted apart from their brothers and sisters when assessed as needing to be adopted together.

99. Children's permanence reports are of a good standard. They provide clear details of children's birth history and reasons why adoption is the best permanence option. They are updated as needed to reflect the children's personalities and interests. Prospective adopters' records and reports evidence appropriate checks being completed. Reports are of a good standard, take account of the views of children and build on adopters' reflections on their own histories. Child placement reports effectively evidence how the adopters are able to meet the child's needs and include adopters' comments on proposed matches and contact plans for the child. All reports seen during the inspection included details on issues of diversity, with the best examples contained within the prospective adopter reports.

100. The agency decision-maker's decisions are recorded in detail, take account of medical reports and legal advice and decisions are made promptly, evidencing effective and timely decisions for permanence.

101. Assessments for adoption support are of a good standard and identify potential risks and needs. However, in a very small number of cases children experienced delays in accessing specialist therapeutic support because assessments were not completed early enough.

102. The support offer to adopters and special guardians is good and a key strength of the service. Adopters are informed of their entitlements during assessment training sessions. The support offer includes an example of very good practice, with the support team having a higher level teaching assistant (HLTA) who works with schools to help them understand the needs of children who are adopted or subject to special guardianship orders. The support is highly valued by schools and parents.

103. The local authority's post-adoption support service provides an array of services to support adopters in providing effective parenting. There are also various children's groups, which include 'Cool Cats', an activity-based group for 7–11 year olds, and 'Teen Club', for teenagers, which has access to a play therapist. The local authority was providing post-adoption support to 100 children at the point of the inspection, 15 of which were children cared for by special guardians. The local authority facilitated 158 letter box contacts during 2014–15, enabling children to maintain appropriate links with their birth families.

104. Life-story books prepared for children are produced in a personalised style, but overall are of variable quality. They are not always made available to adopters at the time of placement.

105. Later in life letters are also of a variable standard and would benefit from being written in child-friendly language and 'plain English' to make them more accessible to children.

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

106. Since 2013 Cheshire East has been one of a group of four north-west authorities participating in a nation-wide initiative to develop a 'gold standard' service for care leavers based on the Care Leavers' Charter.[4] Despite a determined corporate drive to improve outcomes for care leavers this is not yet resulting in a consistently good service. While some positive changes are well established, a wide range of other actions with good potential are either too recent to evaluate or have not yet been implemented. This slow rate of progress reflects the scale of improvements in quality of practice and managerial oversight that were required.

107. At the time of the inspection there were 159 care leavers. Almost all young people in care remain looked after until they are 18 years of age. Care leavers told inspectors they value highly the trusting relationships their personal advisers have built with them over time. As a result of the quality of these relationships the local authority is in touch with all care leavers, and the vast majority are in direct contact. Tracking of young people who are in touch via a third party is effective and appropriately overseen by senior managers. This ensures that this small number of care leavers (four) are assured that the local authority remains concerned about their welfare and is ready to offer support should they choose to receive it.

108. The most recent inspection of children looked after and care leavers in 2011 identified pathway plans as an area for improvement. Significant recent investment in training is not yet resulting in pathway plans that are good, although the quality of support provided is often better than is reflected in the plan. Most plans seen were regularly updated but lacked detailed analysis and often confused the young person's needs with their wishes or actions required. Managerial oversight of the plans does not always focus sufficiently on progress or evaluate whether outcomes for the young person are improving. This has led to significant drift in one case seen and a lack of focus on emerging issues of concern in another.

109. Care leavers live in a wide range of accommodation, the vast majority of which is suitable to their needs. The largest group (46%) live independently. Financial

[4] New Belongings was launched by DfE on 2 September 2013 and has been an innovative and ambitious initiative aiming to raise expectation and aspiration for care leavers. The inspiration for New Belongings came from the care leavers group who meet regularly with the Minister for Children. The project had three main objectives: to embed the principles of the Care Leavers Charter, to join up services to care leavers, as outlined in the Access All Areas report, to bring in the energy of local communities to support care leavers.

support for setting up home is good and at £3,000 is higher than in many other local authorities.

110. Young people receive flexible and tailored support to help them achieve independence. This ensures that most young people move towards independence at a pace that is right for them. Inspectors saw examples of care leavers with additional needs continuing to receiving floating support of up to 50 hours a week, enabling them to live independently. Care leavers spoken to reported that they felt safe in their accommodation, that it was of good quality, and that they were satisfied with the level of support they received.

111. At the time of the inspection six care leavers were refusing appropriate accommodation provided by the local authority. All of them had multiple problems including drug and alcohol misuse, risk of or actual offending behaviour, and emotional health problems. In all cases young people had been offered at least a temporary solution but had refused it. Most were moving between friends and relatives and one was in custody. Personal advisers were making concerted efforts to engage them with services in order to reduce their risk-taking behaviours and to secure sustainable, suitable housing options that were acceptable to them. However outcomes for these care leavers remain uncertain due to the complexity of their needs. Senior managers have insufficient oversight of these care leavers who are homeless and do not routinely monitor the individual circumstances of these highly vulnerable young people.

112. When young people present as homeless at age 16 or 17, housing and children's services complete a joint initial assessment of the presenting issue, followed by a children and families' assessment. In some cases seen, effective mediation at an early stage resulted in young people returning to their families. When this is not achievable young people are clearly encouraged to become looked after.

113. Foyer accommodation is used as a last resort for young people who are not yet adults. At the time of the inspection four young people age 16–17 and nine care leavers aged 18–20 were living in this type of accommodation. Providers complete risk assessments on all young people under the age of 18 at the start of the placement, but do not routinely complete them on older care leavers who may be equally vulnerable. Where this is the case the local authority cannot be assured that this is a safe place to live for these young people. Assessments seen were brief. They considered known risks, but did not specifically address the potential impact of the setting on the young person. Action plans were of better quality and young people were receiving bespoke packages of support and good job and life skills training which was helping them to achieve stability. In the cases seen none of the young people were found to be at risk within the placement.

114. At the time of the inspection, six care leavers over 18 were living with former foster carers under 'staying put' arrangements. A revised 'staying put' policy

was issued in April 2015 but it is too early to evaluate whether this will be successful in increasing the numbers of young people benefiting from these placements. A larger number of care leavers (15) were living in supported lodging arrangements with host families which, while not replicating the same level of support as foster carers, provides mentoring and advice when needed. One young person spoken to by an inspector greatly valued the informal contact he had with the host family, which was sensitive to his needs.

115. Data shows that at 31 March 2014 Cheshire East had a significantly lower percentage of care leavers aged 19, 20 and 21 who were not in education, employment or training (NEET) than comparators. However, at the time of the inspection 52% of 19-, 20- and 21-year-olds and 47% of all care leavers were NEET. This performance falls short of the local authority's aspirations for a gold standard service. Of these young people, 19% are recorded as unable to participate due to disability or because they are parents or pregnant. The majority of sampled pathway plans seen did not have clear and specific targets and actions to help or encourage young people to secure employment, education or training. Managers recognise that they could do more to identify young people who could be helped through the employability scheme.

116. A legacy of poor practice has resulted in some young people leaving school without the skills required to engage in further education and training or to enter the job market. Recent sound and innovative strategies to track and re-engage young people in education have not yet resulted in a marked impact across the full age range of young people who are classed as NEET. These include close work with the virtual school and intensive support pilots to improve young people's motivation to engage in positive activities. A newly commissioned service based on learning from the pilots is due to be launched in August 2015.

117. Academic support from the virtual school to care leavers in higher education is good and the financial support they receive is far higher than many other local authorities provide, ensuring that young people are not deterred from embarking on further study due to financial pressures. At the time of the inspection 12 care leavers (8%) were at university, with a further five due to start in September 2015. This is increasing year on year but the local authority is aware that this is not yet good. In the last academic year one care leaver had graduated from university and two had dropped out. A further 11 young people are engaged in apprenticeship schemes.

118. Drop-out rates are high across the range of educational and training schemes that care leavers begin. The local authority is tenacious in securing alternatives for young people that allow them to start again. Of the 14 young people aged 16–18 years who had dropped out of education or training in the last academic year, 10 had already re-engaged in training that will lead to a qualification, and a further four were due to start in September 2015. In recognition of the need to help more care leavers to make their apprenticeships and training courses a success, local authority funding has been secured to appoint staff to 'Project

Cygnet'. The project has not yet been launched. The local authority does not currently track whether the educational and training courses care leavers complete are effective in assisting them to obtain permanent employment. It has recognised that this is a gap and intends to do so in the future in order to improve careers advice available.

119. Care leavers have access to a wide range of helpful advice and support for their health needs including for their sexual and emotional health and to reduce risk-taking behaviours such as substance misuse. The post of specialist nurse for looked after children aged 16–18 has been vacant since April 2015. While cover is provided, it is not always the same person. This creates a lack of both continuity and specialist knowledge of the particular issues faced by this age group. There is no specialist health resource for care leavers over the age of 18.

120. Recent changes in procedures, underpinned by good strategic partnerships, are showing early signs of more timely involvement of adult services with young people who will require on-going services as a result of their health needs. Consideration at a recently established transitions group of young people with disability, mental health problems or other significant vulnerability is now ensuring that disabled young people have involvement with adult services from age 14 onwards.

121. Care leavers' experience of transferring from children's to adult services, unless they have identifiable significant health needs, remains dependent on the services available where they live. However, in cases sampled of the 58 care leavers out of area they were not disadvantaged by distance.

122. Responses to care leavers vulnerable to sexual exploitation are variable. Young people under 18 who meet the threshold are given full consideration at the child sexual exploitation operational group. The transitions group now considers care leavers at risk of sexual exploitation so that those who need it continue to receive services as a vulnerable adult. However, this is a very recent development and so far only a very small number (three) of young people have benefited as a result. In a very small minority (two) of cases, emerging risk had not been identified early enough, limiting the range of responses available due to the young person's age.

123. The local authority responds well to young people's diversity and identity needs when there is a clear identified need, for example in relation to disability, sexual orientation or gender identity. The potential impact of broader issues such as body image or physical presentation on young people's self-esteem is not always recognised unless raised by the young person.

124. Care leavers receive all appropriate documentation to help them start adult life. Those spoken to by inspectors knew how to complain and how to access their records, and were aware that advocacy services were available. Written information provided to care leavers about their entitlements is outdated but

mitigated by the current good advice from personal advisers. The information care leavers receive about their health history is less well summarised or understood, reducing young people's capacity to make informed choices about their future health needs. The local authority recognises this is a gap. Plans to provide young people with better quality information tailored to their individual needs are well underway.

125. There is an active care leavers' forum that has been central to planning current and future improvements. For example, membership of a credit union for care leavers was set up as a direct result of lobbying by the group. Care leavers spoken to expressed frustration at the pace of change to date but all felt their views were valued and respected.

Leadership, management and governance	Requires improvement

Summary

Since the last Ofsted inspection of 2013, senior and political leaders have worked closely and effectively with the Cheshire East Improvement Board (CEIB) to improve the quality and effectiveness of services for children and their families. Senior and political leaders understand their strengths and weaknesses well. They have taken decisive steps to identify, tackle and systematically address the barriers to providing good services.

This inspection has identified key strengths and improvements. The stronger 'front door' ensures that children who are at risk receive a service that meets their needs. Children in need receive more coordinated and targeted help. Managers have ensured sufficient good quality adoptive and foster families. As a result children are happy where they live and their outcomes improve. However, senior managers need to strengthen some areas of practice before children and families can be confident in receiving a consistently good service. A few areas require further attention to meet minimum standards, for example managers have not ensured consistency in 'step-down' decisions. Effective permanence planning arrangements are not yet in place. Managers have not implemented good processes for assessing placements for children who live with friends and family members.

Achieving workforce stability is a significant challenge, due in part to leaders setting and applying clear practice standards. There is strong political support for recruitment and retention initiatives. Stability within social work teams is improving but there is more work to be done to ensure this improves in all teams and is sustained. Training is comprehensive and social workers feel well supported. They are engaged in the improvement journey and can articulate achievements. The majority of social work caseloads are at an acceptable level but some remain too high. Supervision, although regular, does not always effectively drive plans for children. Personal development plans are not consistently used to strengthen practice.

A well-established and comprehensive audit programme enables managers to effectively analyse practice and drive improvement. Some learning is lost because of the scale of audit work undertaken, and because not all findings and actions are recorded in one place. There needs to be a closer focus on children looked after in this work. Performance information is used well by managers at all levels to track progress against targets. Some forums, such as the Corporate Parenting Board, do not receive comprehensive enough information about looked after children, for example through an annual performance report.

A new electronic recording system has been introduced, strengthening case recording and the availability of management information. The conversion to the new

system has led to some data being inaccurate or unreliable.

Engagement is a real strength, with young people exerting influence at a strategic level in all the key decision-making forums. Actions arising from complaints are not always tracked and used to identify learning needs.

Joint commissioning decisions and arrangements are sound and closely linked to shared priorities, but there are some gaps in service provision for children in need of help and protection and children looked after.

Inspection findings

126. Elected members and senior managers fully understand that establishing a stable and skilled group of first-line managers is fundamental to providing consistently good support to children and families. They are taking appropriate steps to strengthen management skills through a comprehensive management development strategy. Supervision training is mandatory, and an 'aspirant managers' programme has been introduced to help more experienced social workers to take the step up to first-line management. At the time of this inspection some challenges remain; 10 of 22 practice managers in social work teams are employed by an agency, although two further permanent appointments were made during the inspection.

127. The sharp focus on the effectiveness of safeguarding arrangements has meant that some areas of practice, particularly relating to children looked after, have not been sufficiently progressed. Management decision-making and challenge are not robust enough and plans for permanence are not yet assertively progressed for all children looked after, particularly older children. Where decisiveness and rigour are lacking, children experience delays in their needs being met. Senior managers' oversight of arrangements for children looked after to live with connected adults lacks clarity and consistency.

128. Formal and case supervision are regular and social workers report that managers at all levels are available, visible and take a direct interest in individual children and families. However, managers are not consistently using personal development plans to drive practice improvement through supervision and it is difficult to see what difference training is making because explicit links are not made to continual professional development. Strong challenge of frontline practitioners is not yet embedded.

129. Senior managers introduced a comprehensive practice standards document 18 months ago. These standards describe what good social work looks like and have been a useful tool in holding staff at all levels to account for the quality of their practice. Senior managers have consciously lowered their tolerance of poor practice, resulting in some social workers and managers changing roles or leaving the local authority. While this purposeful strategy has contributed to

high staff turnover, it has also led to improvement in the experiences of children and families.

130. The local authority is actively addressing workforce instability and this is a key challenge in providing consistently good services for children and families. The local authority has introduced an ambitious and thoughtful range of recruitment and retention initiatives. Elected members are fully supporting this approach and sustainability is secured through increased funding for the children's social care workforce, such as the provision of supernumerary social workers to minimise the impact of less experienced staff. The involvement of senior managers, including the Director of Children's Services (DCS), in shortlisting and interviewing social workers and managers at all levels demonstrates the strong commitment of leaders to ensuring the right staff are in place. As a result of these efforts agency appointments are declining and permanent appointments are steadily rising. In the 15 months preceding this inspection there were 59 new permanent appointments in children's social care as opposed to just eight in the preceding two years. In 2013–14, 49 agency staff were appointed. This reduced to 39 in 2014–15, and just three agency staff have been appointed so far in 2015–16, demonstrating improving stability. Social work caseloads are rigorously tracked and average caseloads are within target range at 22. However some remain too high at 33–35.

131. The local authority continues to invest in the Step-up to Social Work programme and also sponsors high-calibre students from local universities. The professional capabilities framework has been applied creatively to enable social workers to progress their careers as they increase their skills. The appointment of a group of social worker practice champions, with direct links to the DCS and the Head of Service, is contributing to improvements in frontline practice. For example, these social workers are helping to add depth and analysis to case recording through the introduction of laminated prompt cards.

132. The workforce development strategy lays out the local authority's aspiration for the workforce with a coherent plan to achieve this. Training needs analyses, complaints and case audits are used well and are helping the workforce development team to identify priorities. Targeted training focuses on practice skills through, for example, the use of a specialist theatre company to increase social work confidence and skill in engaging with challenging families. Gaps remain, such as in ensuring all staff understand and comply with the Care Planning Regulations 2010.

133. Staff are issued with high quality equipment, such as smart phones and laptops, and the DCS personally oversees this to make sure that all new starters have the right tools to carry out their roles. Daily ring-fenced time enables social workers to maintain their case records but this is not yet being consistently well used to ensure clarity in all case records. The programme handbook for social workers in their assessed year in practice (ASYE) is comprehensive. A large number of social workers (23) are in the current ASYE cohort and the level of support for these staff, such as supervision, mentoring,

training and personal study, is appropriate. Most ASYE social workers spoken to say they are well supported and that their caseloads are protected. They find reflective sessions helpful in developing their practice skills. Social workers value the on-going support of the ASYE coordinator in their second year of employment.

134. Detailed and comprehensive performance information ensures managers at all levels have a clear and realistic understanding of the strengths and weaknesses in services for children. Where commentary and analysis are included this is particularly useful, such as the 'performance book' used by the Improvement Board. Management information reports used in team 'challenge meetings' are helpful to first-line managers. These meetings, described by one practice manager as 'uncomfortable but necessary', are contributing to improvements such as assessment and visiting timescales. However, learning from this approach is not yet being consistently translated into effective challenge between frontline managers and social workers.

135. There is no annual performance report to outline and explain the local authority's progress compared with previous years and against national performance and statistical neighbours. This would assist political leaders, partners and staff to understand and follow the improvement journey, to be clearer about which data is important and what this performance actually means for children.

136. Senior managers have taken appropriate steps to replace the previous electronic recording system, launching a new system in October 2014. The migration of data has led to some anomalies. As a result managers are not always confident about what some of the data is telling them. Where it is known to be wrong, managers are unable to identify readily the right data without checking individual children's records or undertaking themed audits to fully explore the issue. This is inefficient and not leading to a consistently coherent overview of frontline practice.

137. The quality assurance framework is comprehensive and includes a strong emphasis on case auditing. The employment of a team of independent auditors ensures the on-going prioritisation of this work. The audit programme is closely aligned with that of the Cheshire East Safeguarding Children Board (CESCB). Children, parents and multi-agency partners are involved, adding depth to audit findings. Improvements and areas of weakness are identified well and this was reflected also in the audits undertaken for the cases tracked for this inspection. Managers take appropriate steps to improve practice, for example commissioning mandatory training for staff undertaking child protection enquiries. Managers communicate findings from audits to staff via a newsletter. The inclusion of parents' and children's own words in this newsletter strengthens these key messages. Social workers reflect on and challenge audit findings and find this process helpful.

138. It is difficult for senior managers to evidence progress in all areas identified from audits because actions and learning are not all recorded in one place. The audit programme is not sufficiently focused on the experiences of children looked after. Careful thought needs to be given to what, how much and how often practice is analysed in this way. Senior managers also need to ensure they achieve the right balance between examining practice and driving and modelling improvements.

139. The participation of children and young people is a real strength in Cheshire East. Political and senior leaders create meaningful opportunities for young people to join them in strategic thinking and planning. Young people from the youth council, which includes children looked after and care leavers, are consistently represented and exert influence at most key forums such as Corporate Parenting Board, Children's Trust Board and the Local Safeguarding Children Board. A young person's version of the children and young people's plan has been 'youth proofed' and two young people co-chair the Children's Trust board with the interim DCS. They feel listened to and that they have significant influence in this forum. They describe the Lead Member for children as 'passionate' about young people's issues and they appreciated the Chief Executive listening to their views in the recent DCS appointment. Young people themselves say that the Leader of the Council, through his active interest and engagement in the youth council's focus on emotional health and well-being, is a 'massive force behind young people's mental health'.

140. Although the participation of young people is strong, the local authority is not making the most of all opportunities to learn about the effectiveness of its services. Analysis of complaints does not consistently result in effective action to improve practice. Recommendations from complaints do not sufficiently explore underlying issues and do not result in a reduction in the number of complaints received.

141. The key priorities within the children's improvement plan, the LSCB business plan, the children and young people's plan and the health and wellbeing plan are appropriate and aligned. They relate to improving the quality of frontline practice, listening to and acting on the voice of children and young people and effective partnership as ingredients for delivering good outcomes for children and families. Respective responsibilities for delivery against the priorities are clear.

142. Clear and appropriate governance arrangements are in place between key strategic bodies, including the CEIB, Overview and Scrutiny and the LSCB. This promotes the sharing of priorities, enables political and strategic leaders to hold each other to account and facilitates helpful communication. Duplication is minimised. Strategic, senior and political leaders such as the DCS, Chief Executive, Lead Member, Chair of the Improvement Board and Chair of LSCB, meet regularly. They use these meetings appropriately to challenge, scrutinise improvements, consider professional development issues and share information.

143. The joint strategic needs analysis now includes an appropriate range and level of detail about children, including vulnerable children. This was an area for improvement from the last inspection. The Health and Wellbeing Board was established in April 2013. It takes an active interest in some key areas such as commissioning of domestic abuse services and child sexual exploitation, but its overall focus on children, including cared for children, is less well developed. Leaders are aware of this and the Lead Member for Children now has a defined role to ensure vulnerable children are prioritised, although it is too soon to see the impact of this.

144. The local authority is ambitious for the children in its care and care leavers. The Corporate Parenting Board reviews progress against actions from the corporate parenting strategy, most of which are on track. It considers key documents such as fostering and adoption reports but does not receive comprehensive enough information, for example relating to how often looked after children see their social workers. The Corporate Parenting Board, which is well-attended by elected members, needs to increase its confidence and challenge in improving the quality of services for children looked after. It does not yet include a foster carer or supported housing provider. Although ambition is high, this has not always been translated into decisive action. Some important changes have taken too long, such as the review of the Pledge and ensuring that all care leavers have access to a comprehensive summary of their health histories.

145. Children looked after and care leavers routinely attend Corporate Parenting Board meetings and use creative games and tools to help attendees understand the issues affecting them. Young people are designing and running the next awards ceremony, because they would like it to be a more inclusive and positive event.

146. Positively, any business submitting a competitive tender for council work must make a commitment to providing apprenticeships or employment opportunities to care leavers. Additional council funding has been secured to run 'Project Cygnet', a new initiative where support workers will help care leavers to make their apprenticeships a success. It is too early to judge the impact of this project. Care leavers are well-supported to attend university and numbers of care leavers choosing this path are increasing each year. The corporate parenting strategy is clear that more care leavers need to be helped to take this step.

147. The Lead Member for Children attends the LSCB, the CEIB and Children's Scrutiny Committee, and this ensures good oversight and understanding of what needs to improve. The Children's Scrutiny Committee has been instrumental in improving working conditions for staff, and elected members undertake regular visits to frontline teams. Through the child sexual exploitation task and finish group elected members analysed the effectiveness of partnership arrangements through visits to the missing from home service, police, taxi licensing and social workers. This highlighted challenges relating to cross-border working. Child sexual exploitation remains a priority for Children's

Scrutiny for 2015–16. The committee does not yet receive broad enough performance information to ensure it can take an overview of patterns and trends in performance. A programme of safeguarding training is in place for newly elected members, with refresher courses for those who have already attended.

148. There are clear lines of governance between the recently formed Joint Commissioning Group, the Health and Wellbeing Board, Children's Trust Board and the LSCB. This new group has brought a more coherent approach to commissioning arrangements. Most commissioning decisions evidence good insight into local need, such as increasing the capacity of the missing from home service and strengthening the range of voluntary sector domestic abuse services. The advocacy service is sufficient to offer a service to all looked after children and children subject to child protection plans but does not yet support children in need. Sustained investment in a good range of in-house services such as @CT and Visyon, which uses practical and therapeutic approaches to help families maintain stable and healthy relationships, is leading to positive outcomes for children and young people. Families themselves say that these services are improving their lives. The local authority has ensured that there are sufficient foster carers and adopters to meet the needs of Cheshire East children looked after.

149. Some commissioning gaps remain, such as the 16+ looked after nurse vacancy and delays in the clinical commissioning group committing sufficient funding to extend this provision to 18–25 year olds. Some children looked after have waited too long to be linked with an independent visitor. There is no joint commissioning strategy in place. This means that there is no shared document stating partners' collective and individual responsibilities to ensure children's need are met, both now and in the future.

150. Multi-agency partnerships have been strengthened since the last inspection in 2013. Senior managers work openly and effectively with the Local Family Justice Board and Cafcass. The co-location of police, the missing from home service and voluntary domestic abuse services with the ChECS 'front door' team has been achieved through close collaboration, in particular with the police. The caring and proactive approach taken by local schools is an important protective factor for many of the vulnerable children considered as part of this inspection.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement

The arrangements in place to evaluate the effectiveness of what is done by the authority and board partners to safeguard and promote the welfare of children require improvement.

Executive summary

There is a clear commitment from the independent chair, the local authority and partner agencies to improve the effectiveness of the Cheshire East Safeguarding Children Board (CESCB). Significant progress has been made, particularly over the last year. Improvements are still needed to further the Board's oversight of practice and coordination of multi-agency safeguarding functions.

The CESCB is independently chaired and appropriately constituted. It is well supported by partner agencies, which are at the right level of seniority to be able to make decisions and commit resources. The inclusion of young people in the Board's membership ensures the child's voice is central to its work and is a significant strength.

There are clear governance arrangements between the Children's Improvement Board, Children's Trust and the CESCB with shared objectives and strong ambition to improve partnership working. Strategic links with the Health and Wellbeing Board (HWB) are not explicit and the children's agenda within this body is not sufficiently developed.

The focus of the CESCB's work has been on the priorities of the Improvement Board. The Board has undertaken a great deal of development, challenge and audit work to support practice improvements in line with the work of the Children's Improvement Board. Other vulnerable groups of children, including those who are looked after, have not benefited from the same level of scrutiny and challenge. The Board has no oversight or connection to the Local Family Justice Board. Therefore it cannot assure itself that children's needs are being met in relation to public and private proceedings.

Consideration and scrutiny of early help are not sufficiently embedded in the strategic oversight and work of the CESCB. The focus has been on increasing the number and quality of CAFs and the thresholds for referral to social care. The Board has not sufficiently considered inconsistencies in the stepping down of cases to lower levels of intervention. Escalation processes are underused.

There have been no serious case reviews (SCR) commissioned in the last four years and those cases considered at the case review sub-group have not been referred to

the National Panel. Therefore, external monitoring of the threshold for undertaking a SCR has not happened. There is some evidence that learning from other case reviews is impacting on practice but this is not widespread, for example the development of a pre-birth assessment process so that agencies coordinate work to safeguard children at the earliest opportunity.

Ofsted has not received any serious incident notifications since 2012. The Board is planning to audit cases that have involved serious harm to a child to see if the newly reviewed pathway process is working. Use of performance data within the CESCB is not yet sufficiently developed. The Board acknowledges that the data set does not yet fully reflect the work of the partnership. More work is needed to reach an agreement about which multi-agency data should be included in order to ensure robust oversight and scrutiny of safeguarding practice.

Although there is a lot of work being undertaken across the partnership in relation to female genital mutilation, such as an awareness-raising campaign about the 'cutting season', it is, at this stage, uncoordinated.

In response to high numbers of children subject to child protection plans due to neglect, the CESCB launched a neglect strategy in January 2015. Plans are in place to undertake further work to embed use of the tools before auditing to assess the impact early in 2016.

Recommendations

151. Complete work to develop the performance management framework so that service effectiveness can be evaluated rigorously across all agencies

152. Provide regular scrutiny of services for looked after children. Monitor and review the application by partner agencies of the threshold framework and take appropriate action where necessary.

153. Evaluate the impact of the neglect strategy and disseminate the findings to help agencies improve their practice.

154. Develop links with the Local Family Justice Board so that CESCB can monitor how well the needs of children in public and private law proceedings are met.

155. Review the arrangements for monitoring the quality of private fostering work.

156. Improve the influence of CESCB in the work of the Health and Wellbeing Board to ensure that safeguarding is embedded within its priorities.

157. Develop and implement a coordinated strategy in relation to female genital mutilation so that the impact of multi-agency work within Cheshire East can be evaluated and understood.

158. Implement a protocol that outlines when the National Panel should be notified about SCRs and incidents in order to strengthen scrutiny of decision-making.

Inspection findings – the Local Safeguarding Children Board

159. The CESCB has an independent chair, is appropriately constituted and is supported by the commitment of partner agencies represented at the right level of seniority who commit resources to the Board and to the provision of safeguarding services. The sub-groups have recently been reviewed and each has an action plan to progress the work of the Board. Two lay members are involved at Board and sub-group level and are taking part in work to raise awareness of safeguarding within local communities. This is in its early stages.

160. The independent chair has been in post for two years and his contract has recently been extended for a further year. He has led significant development work and is a strong and credible chair who has assisted partner agencies to take joint ownership and accountability for safeguarding across Cheshire East. For example, board members undertake visits to frontline services to improve understanding of partner agencies' involvement in delivering safeguarding services. This has included visits to Cheshire East Consultation Service (ChECS) health visiting services and the Accident and Emergency Department. There are plans to develop multi-agency frontline practice standards to ensure consistency of practice across the partnership.

161. There are clear governance arrangements between the Children's Improvement Board, Children's Trust and the Safeguarding Board with shared objectives and priorities. The Chief Executive and the Director of Children's Services (DCS) meet regularly with the independent chair, although the minutes of these meetings do not evidence that the chair is being held to account for the effectiveness of the Board.

162. CESCB have signed up to the Pan-Cheshire Learning and Improvement Framework, which has been localised for Cheshire East. The Board has a clear learning culture using external scrutiny and challenge well to help its development. This has included a recent peer challenge, the use of reflective reviews and the introduction of 'True for Us' reviews. Through these reviews national SCRs are considered against practice within Cheshire East to see whether there are any potential local lessons or development areas.

163. The Board offers a comprehensive range of training and take-up is good with 87% of places filled. This success is due in part to the introduction of a charging policy when professionals fail to attend. Online training to increase participation further is planned but not yet implemented. The learning and development sub-group has recently broadened its focus to ensure it

incorporates more than just training. It appropriately uses learning from case reviews and child deaths to influence the subject and content of training and also to inform local initiatives such as the recent safe sleeping campaign. The training is very well received by professionals and the annual impact evaluation shows that the vast majority of respondents feel it has influenced their practice. The Board is strengthening its approach to ensure a better understanding of how training and development is improving practice.

164. There is significant evidence of the Board holding partner agencies to account. An independent panel of Board members and young people undertake sector-specific challenge sessions with partners to help identify where they need to improve their safeguarding arrangements and oversight. The recommendations are formalised into an action plan and agencies are required to report on progress. All board members spoken to were able to provide examples of effective challenge and how this had changed their practice. For example, the police improved their process for completing vulnerable person's alerts, and public health has extended the remit of their school nursing service to include children who are not in education. In addition, Board members identified that as a result of the challenge, safeguarding within their own agencies has been given greater focus and resource allocation.

165. The Board has a well-used and up-to-date challenge log that identifies challenges raised and their outcomes. Accountability would be further strengthened if the Board considered the continued impact of these challenges when signing off the action plans as complete.

166. The voice of the child is an area of real strength within the work of the board. Engagement with young people is innovative and influential, and there are clear examples of where this has had an impact on policy development and service delivery. For example, a 'Takeover Day' in November 2014 led to two young people being appointed to the Board and all agencies being challenged to demonstrate how they ensure true involvement of young people in the services they provide. These two highly motivated and knowledgeable young people are fully engaged with the Board and work effectively with other young people to influence and shape safeguarding priorities. They feel they are listened to and that their contribution to safeguarding is important.

167. The Board undertook an effective section 11 audit in 2014 and the reach of this was extensive, involving leisure services, housing and regulatory services. Partners were required to submit supporting evidence and the analysis of the audit led to agencies developing action plans which the Board monitors to ensure progress.

168. The Board is well resourced and contributions are made by all agencies supported by the local authority business unit that works across the CESCB and the Improvement Board. The role of the manager within this service has ensured that the two agendas are aligned. The Board has recently appointed a

performance officer in order to promote the development of the delayed performance framework and further strengthen this work.

169. The Pan-Cheshire Child Death Overview Panel (CDOP) has recently appointed a new chairperson. The 2013–14 annual report identified a number of areas for development, which the chair followed up. These include writing to Public Health to ensure the smoking in pregnancy campaign continued and the development of the safe sleeping programme. However, there is currently no suitably trained health professional to undertake a home visit following the death of a child. This is despite the chair writing to health commissioners to ask that this was prioritised. This is to be followed up as part of the work plan for the coming year. There is a lack of data specific to Cheshire East available but firm plans are in place for this to be part of the work the Board will be undertaking, as well as introducing an action log to capture areas for development.

170. Child sexual exploitation arrangements are coordinated and delivered well at a local and pan-Cheshire level through the CESCB and the community strategic partnership. A range of strategic and operational forums effectively deliver the multi-agency strategy, including the pan-Cheshire and CESC child sexual exploitation and missing from home sub-groups. The sub-group structure reflects how well this area of safeguarding is prioritised within Cheshire East with a multi-agency champions group and an operational group collectively demonstrating determination to ensure young people are safeguarded.

171. Intelligence is shared and appropriate plans are developed for individual children and young people. The police and local authority work together well, for example in the development of a consistent pan-Cheshire communication strategy and the development and implementation of a screening tool across the four local authorities. Partners and senior and political leaders understand the prevalence of child sexual exploitation and continue to work together to oversee and reduce risk and ensure the provision of appropriate support.

172. The Board receives a comprehensive child sexual exploitation report twice yearly which details prevalence, work undertaken and planned strategic development. The Board has been influential in the decision to appoint further dedicated child sexual exploitation staff at the front door, which is leading to more timely identification and provision of services for those children at risk of going missing or being sexually exploited.

173. On a casework level, social workers are not yet consistently making links between what happens when children go missing from home and care, and potential child sexual exploitation risks. The evaluation of return interviews is not embedded and social workers are not using the information from return interviews to influence direct work with young people. CESCB has not sufficiently scrutinised or challenged partners about this aspect of frontline practice.

174. The CESCB website is accessible, easy to navigate and well used, especially for details about training. It has a comprehensive, up-to-date set of procedures which are interactive. They offer process advice as well as research information, legislation and practice guidance. The website highlights latest news and updates to ensure that those accessing the site can see any changes on the front page. It also has a Twitter account with regular tweets for updating staff.

175. The annual report for 2014–15 is in draft and a report detailing the priorities for the coming year was agreed by the Board in June. The 2013–14 report provides an evaluation of safeguarding work and sets out priorities and a work plan that are linked to the Improvement Board work. A joint session of the Children's Trust, the Improvement Board and the CESCB has been held and young people have helped to inform and influence the priorities for this year but the outcome of this cannot be evaluated as yet.

176. The work in relation to female genital mutilation is not yet coordinated. There is an agreed CESCB procedure in place and individual agencies are developing their response. The police have specialist female genital mutilation officers in place. The Board has assisted with raising awareness by sending out letters to partner agencies and this has led to a recent referral from a school. Health agencies record the prevalence of incidents but this is not formally reported to the Board. There is no dedicated training programme, although there have been well-received pan-Cheshire events. The reach of these has been limited to 80–100 professionals but there are plans to address this with additional sessions in the autumn.

177. The Prevent agenda is coordinated via the Community Safety Partnership (CSP). The police have led the work to date. They have a dedicated coordinator in place for Prevent, the initiative to prevent people becoming terrorists, and one for Channel, a mechanism to support people who may be vulnerable to extremism. There has not been a Channel Panel held as yet but referrals have been made to children's social care. Joint work has also taken place with the police and a multi-agency group of professionals to produce an action plan to reduce risk. There is currently one open case and four which have been closed in the last five months. The oversight of this work is in its very early stages but will be monitored via the CSP on a quarterly basis.

Information about this inspection

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

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

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

Ofsted produces this report of the inspection of local authority functions and the review of the Local Safeguarding Children Board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

The inspection team consisted of 10 of Her Majesty's Inspectors (HMI) from Ofsted and one associate inspector (AI).

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