Ofsted
Piccadilly Gate
Store Street
Manchester
M1 2WD

T 0300 123 1231
Textphone 0161 618 8524
enquiries@ofsted.gov.uk
www.gov.uk/ofsted

22 August 2025

Amanda Perraton
Executive Director for Children and Families
Health and Wellbeing Directorate
Cheshire West and Chester Council
Floor 2
Wellington Road
Ellesmere Port
CH65 0BA

Dear Amanda

Focused visit to Cheshire West and Chester children's services

This letter summarises the findings of the focused visit to Cheshire West and Chester children's services on 23 and 24 July 2025. His Majesty's Inspectors for this visit were Kathryn Grindrod, Rebekah Tucker and Nabeel Hussain.

Inspectors looked at the local authority's arrangements for children in need or subject to a protection plan.

This visit was carried out in line with the inspection of local authority children's services (ILACS) framework.

Headline findings

The recently appointed senior leaders have quickly developed an accurate understanding of the quality of services for children in need of help and protection. Comprehensive plans are in place to address areas for improvement, including those identified during the previous ILACS inspection in 2024. Fundamental issues, such as workloads and the stability of the workforce, have improved.

Other development work is at an early stage and there are areas of social work practice and management oversight that continue to require further development. For example, children's plans are still not routinely focused on children's outcomes. Agreed interim actions to safeguard children are not always clearly articulated. Assessment and support of children in private fostering arrangements, while somewhat improved, is still not robust enough to ensure that sufficient safeguards are in place for children. Quality assurance activity is not always accurate or impactful and management oversight and decision-making are not well documented.

What needs to improve in this area of social work practice?

- The quality of plans for children, including contingency planning and safety planning. (Outcome 1, national framework)
- The timeliness of checks of private foster carers. (Outcome 3, national framework)
- Management oversight and recording of decision-making. (Enabler 3, national framework)
- The accuracy and impact of quality assurance activity. (Enabler 2, national framework)

Main findings

The response to most children in need of statutory help and support is prompt. Child-in-need plans are developed with appropriate partner agency involvement and, typically, key issues impacting on children's experiences are clearly identified. Children and their families are encouraged to be involved in meetings to help shape their plans. A range of effective support is offered to help parents and children address issues of concern.

Child-in-need plans are not always specific about the intended outcomes for children. The success of plans is often measured by parental engagement or attendance at groups and meetings. Children's experiences are not always clearly established to ensure that any improvements can be sustained.

Child-in-need plans are reviewed regularly, with appropriate partner involvement. Multi-agency support for families is promptly secured and there are effective working relationships between social workers, partners and families. This means that plans are usually effective in improving children's experiences, despite measures of success not always being about children's experiences.

For some children, there are unnecessary delays in convening strategy discussions when risks of significant harm are identified. This means that a full and accurate multi-agency understanding of risk is not promptly available to inform decision-making. Children at immediate risk of harm are visited promptly by social workers, alongside police colleagues, when necessary. Children are seen and spoken to away from their parents when appropriate, to establish their wishes, feelings and ongoing safety.

The recordings of strategy discussions are detailed and appropriately consider history and holistic issues and concerns. Appropriate actions are usually agreed at strategy discussions to further assess concerns and take necessary action to safeguard children. Health colleagues do not always attend short-notice strategy discussions, meaning decisions are not always based on full multi-agency information.

Social workers verbally agree with parents or care givers any immediate actions to keep children safe pending further enquiries and assessment. These actions are not routinely shared in writing with families and other professionals. This lack of clarity undermines the effectiveness of interim plans for children's safety.

Child protection enquiries are thorough. Children are spoken with during enquiries and their views inform subsequent decision-making. Appropriate decisions are usually made at the conclusion of these enquiries, although they are not always well documented. Likewise, the overall response to risk, along with management oversight and scrutiny of children's safety, are not always well recorded. This means there is a lack of clarity about what has been decided and why.

Most child protection plans identify key issues impacting on parenting capacity and children's experiences. Core groups are well attended by partners and families and result in plans being updated at regular intervals. As with child-in-need plans, the success of child protection plans is sometimes measured by parental engagement, not impact for children. This can contribute to the sustainability of improvements not being fully understood.

Experienced child protection chairs do not currently have the capacity to routinely oversee the progress of child protection plans in between child protection conferences. This can lead to potential drift in planning not being promptly identified and addressed. The local authority had already agreed extra capacity within the service prior to this visit. When child protection chairs raise concerns about the progress of children's plans, social workers and managers are responsive and take prompt action.

Contingency plans are not routinely devised for children. This makes it difficult for parents to understand when and why alternative action would be taken, and what that action would be. It also means that children may experience reactive planning should concerns about them escalate.

Children are stepped down from child protection planning when it is appropriate. Detailed actions are agreed at the final child protection conference to ensure that families continue to receive the support they need. For a small number of children, child-in-need plans end without successful completion of agreed actions. This risks concerns to children escalating again and repeated periods of statutory intervention, especially when concerns are about longstanding neglect.

Children who are the subject of plans are visited regularly by their social workers and effective working relationships are formed. Children's wishes and feelings are sought and are used to shape their assessments and plans. Professionals working with children carefully consider who is best placed to offer support and work with children depending on their individual needs. This leads to better outcomes for children.

A recent review of the private fostering service has led to changes in procedures. There have been some improvements in practice since the inspection in 2024,

although revised procedures are not fully embedded. Children who are privately fostered are now visited promptly and with appropriate frequency. Assessments are completed in appropriate timescales. Checks of carers are still not requested and completed in a timely manner, leaving children living with people who may pose unknown risks to them. Review meetings for children in private fostering arrangements do not review the ongoing appropriateness of the arrangements. There remains more to do to safeguard children who are privately fostered.

The public law outline (PLO) is well understood by practitioners. There are some children who are the subject of pre-proceedings who have experienced delay in decisive actions and decision-making. This legacy practice is still impacting on some children's progress. More recent practice has indicated an improving picture, with no delays for children who have entered the pre-proceedings phase of the PLO more recently. Letters before proceedings and review letters are now clear about concerns, while being sensitively written.

Case supervision happens regularly, although the quality and impact on social work practice is variable. It frequently lacks reflection about children's experiences and whether social work practice could have a better impact on children's outcomes.

Management oversight and decision-making are not routinely recorded on children's records, particularly in the child-in-need teams. This means that the rationale for decisions is not always clear and may leave workers unsure about what they should do, what has been decided and why. The impact frontline managers have for individual children is not strong overall. Leaders had recognised this prior to this visit and work to develop managers' skills and impact is underway.

Social workers have manageable caseloads. They value the training offer and that their development is prioritised. Newly qualified social workers are well supported, and longer-qualified workers receive positive career development support. Social workers enjoy working in Cheshire West and Chester and feel that they are supported by their peers and managers at all levels.

There has been progress in performance management of social work practice and leaders now have a robust picture of data and compliance. Routine practice reviews continue to be overly optimistic at times and are not always helpful in improving practice with children. They do not provide an accurate overall picture about the quality and impact of day-to-day social work practice. Leaders are aware of the shortfalls in quality assurance activity and have secured sector-led improvement partner support to develop and strengthen this area of work.

Leaders are aware of the areas for development and the strengths identified during this visit. They have plans at various stages of execution to develop the identified areas for improvement, and these are starting to have an impact on practice in some areas. There is strong corporate backing and investment to support these plans, including increased capacity in key areas such as quality assurance activity.

Ofsted will take the findings from this focused visit into account when planning the next inspection or visit.

Yours sincerely

Kathryn Grindrod

His Majesty's Inspector