Wiltshire Council

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: 22 June 2015 – 16 July 2015

Report published: 1 September 2015

Children's services in Wiltshire require improvement		
There are no widespread or serious failures that create or leave children being harmed or at risk of harm. 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 when any widespread or serious failures have been identified by the local authority and are being effectively addressed, but the characteristics of good leadership are not in place.		
1. Children who need help and protection		Requires improvement
2. Children looked after and achieving permanence		Requires improvement
	2.1 Adoption performance	Requires improvement
	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.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates a children's home for short break respite which was judged to require improvement at the most recent Ofsted inspection.
- The previous inspection of the local authority's arrangements for the protection of children was in July 2013. The local authority was judged to be adequate.
- The previous inspection of the local authority's services for safeguarding and looked after children was in March 2012. The local authority was judged to be adequate for children looked after and inadequate for safeguarding.

Local leadership

- The Director of Children's Services has been in post since December 2006.
- The chair of the LSCB has been in post since October 2012.

Children living in this area

- Approximately 103,000 children and young people under the age of 18 years live in Wiltshire. This is 22% of the total population in the area.
- Approximately 11.4% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 9.4% (the national average is 17%)
  - in secondary schools is 6.8% (the national average is 14.6%).
- Children and young people from minority ethnic groups account for 5.3% of all children living in the area, compared with 21.5% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Other White background and Mixed background.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 4.5% (the national average is 18.7%)
  - in secondary schools is 4% (the national average is 15%).

[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.

- Wiltshire is a large rural county with one of the highest military populations in the country. In July 2015, 8.2% of the school population came from military families.

Child protection in this area

- At 30 June 2015, there were 3,038 open cases where children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 2,819 at 31 March 2014.
- At 30 June 2015, 381 children and young people were the subject of a child protection plan. This is a similar to 396 at 31 March 2014.
- At 30 June 2015, 32 children lived in a privately arranged fostering placement. This is an increase from 11 at 31 March 2014.
- Nine serious incident notifications have been submitted to Ofsted in the previous three years and no serious case reviews have been completed or were on-going at the time of the inspection.

Children looked after in this area

- At 30 June 15, 400 children were being looked after by the local authority (a rate of 39 per 10,000 children). This is similar to 395 (38 per 10,000 children) at 31 March 2014. Of this number:
  - 112 (or 28%) live outside the local authority area
  - 35 live in residential children's homes, of whom 51% live out of the area
  - 11 live in residential special schools,[3] all of whom live out of the area
  - 313 live with foster families, of whom 22% live out of the authority area
  - eight live with parents, of whom 25% live out of the authority area
  - seven children are unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been 28 adoptions
  - 26 children became subject of special guardianship orders
  - 173 children ceased to be looked after, of whom 8% subsequently returned to be looked after
  - 11 children and young people ceased to be looked after and moved on to independent living
  - no children and young people who ceased to be looked after are now living in houses of multiple occupation.

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

Executive summary

An inspection of safeguarding and looked after children in March 2012 judged services for looked after children as adequate and safeguarding as inadequate. This resulted in the local authority implementing a comprehensive improvement programme. An inspection of local authority arrangements for the protection of children in July 2013 judged services to be adequate. While the formal Department of Education intervention arrangements ended in early 2014, the local authority has maintained an improvement board to ensure that the improvements are sustained. The trajectory for improvement is positive.

There is clear political support to the Children's Services Leadership Team (CSLT) in Wiltshire. This is further enhanced by the level of support and oversight provided by the Lead Member and Director of Children's Services (DCS), who proactively challenge and scrutinise performance. There is a strong culture of learning and ongoing self-evaluation in Wiltshire and this has ensured that the local authority has a good understanding of its strengths and weaknesses. However, the pace of change and development has been adversely affected by the challenges of recruiting permanent staff at most levels. Recent appointments at strategic and operational level have been strengthened by additional funding for increased social work staff across the service, coupled with an increasingly stable and experienced workforce.

Until recently too many children helped by two of the safeguarding and assessment teams in Wiltshire have experienced frequent changes of allocated social worker. Despite this, most social workers know their children well and now make timely, purposeful visits to them. Social workers are now undertaking more good quality direct work with children and this is contributing to improving outcomes.

The impact of management oversight is not yet consistently leading to improved outcomes for children. While quality assurance processes are now well embedded and have contributed to improvements in casework, performance information is not consistently analysed or used effectively to target activity and improvements.

Clear and continuous improvement in the overall management and delivery of early help services in Wiltshire is evident. The local authority has worked well to improve the quality and oversight of these services but the quality of assessments remains variable and partners' understanding of the early help offer remains too limited.

Children in need of help and protection receive a responsive and proportionate response to their identified needs. Immediate risk to children receives a prompt and effective response. Child protection enquiries are timely and robust. Information sharing is effective and an area of good practice. The quality of recent assessments is improving and the quality of plans continues to develop to ensure that they are specific and succinct. However, children's ethnicity, language, race and sexual orientation are not always well considered by social workers. Child protection chairs monitor the progress of child protection plans and ensure that drift and delay do not occur. However, step down arrangements to early help are not monitored robustly.

Until recently arrangements in Wiltshire for coordinating multi-agency responses to children missing from home or school have not been effective. Missing return interviews have not always been routinely offered and information has not been collated and analysed in order to target resources and inform practice.

While the local authority and its partners were initially slow to implement arrangements to support children and young people at risk of child sexual exploitation, young people now receive a timely and well-coordinated protective response. The child sexual exploitation screening tool has been revised in order to make it simpler and easier to use and is about to be re-issued. The Wiltshire Risk Management Group (WRMG) is well-embedded and effective in monitoring risks and coordinating multi-agency responses to the most vulnerable children and young people, including those who are at risk of radicalisation. Prior to the inspection the recording of investigations into allegations against professionals was not sufficiently robust, though no children were found to be at risk as a result.

The local authority has sound arrangements in place for children who are on the edge of care. Decisions to look after children and young people are appropriate and mostly timely. Children and young people now enter care when they need to.Timeliness of care proceedings has significantly improved over the last year following targeted management activity. Arrangements to drive forward the permanence plans for all children are not robust and management oversight is not yet having a consistent impact on the quality of practice. While placement stability for looked after children is good, placement choice for older children is limited.

Outcomes for the majority of children in care are improving through good quality education and leisure provision. While children in other areas of the service experience frequent changes of social worker, most children in care have had a consistent social worker with whom they can build a relationship. The role of the independent reviewing officer (IRO) is too limited. Recommendations at reviews are not well monitored or recorded in a timely way and IROs are not routinely monitoring arrangements for children between reviews.

Children in care now receive an improving level of support in their transition to adulthood. The number of care leavers in employment, education and training is now good, with effective use of apprenticeships across the council. Pathway plans are not always comprehensive and care leavers lack information about their health history. This does not help them make informed decisions about their health needs.

While some children experience a sensitive and effective service from the adoption team, others experience delays in permanence planning and the identification of suitable adoptive placements. Although the timeliness of assessments of adopters is not always sufficiently rigorous, the recruitment of potential adopters has been appropriately targeted in the last year. The local authority has an understanding of where improvements in permanence planning and matching need to be put in place but progress has not been fully demonstrated.

Recommendations

1. Review the use of data and other sources of performance information to ensure it is used systematically across all areas of the service to improve outcomes and services for children and young people.

2. Ensure that all children and families who need early help are assessed and that their identified needs inform timely plans that are outcome-focused, specific and measurable, and that lead professionals are identified promptly.

3. Ensure that step-down arrangements from children's social care to early help are robust so that children and families receive the right level of help and support when they need it.

4. Provide all social workers with access to good quality management oversight and reflective supervision.

5. Monitor and evaluate the use of the child sexual exploitation screening tool to ensure that risks that children and young people may be exposed to are appropriately identified and responded to.

6. Improve social work practice so that children's and young people's age, disability, ethnicity, faith or belief, gender identity, language, race and sexual orientation are fully taken into account.

7. Ensure that all children who go missing from care and home are offered a return interview, and that information gathered during these interviews is collated and analysed to identify patterns and trends to ensure children receive the support they need and further missing episodes reduce and stop.

8. Strengthen the impact of the independent reviewing service to improve the monitoring of recommendations between reviews and timely completion of review minutes, ensuring that more effective and timely challenges are made to tackle drift in permanence planning.

9. Improve the timeliness of adopter assessments and matching process to minimise delay for those children who require adoption and target the recruitment of adopters for children with more complex needs, family groups and older children.

10. Provide care leavers with regular opportunities to contribute to the development of an effective pathway plan that responds to their needs. Ensure they are provided with a copy of their health histories and made aware of their entitlements.

11. Analyse the reasons why some young people are not engaging with care leaving services and use this information to develop effective strategies to combat perceived barriers.

Summary for children and young people

- Services for children who need help and protection in Wiltshire were found to be inadequate in 2012. Since then, council leaders and managers have worked hard to improve services and have made progress. Inspectors found they still need to do more to make services good and have judged them as requiring improvement.
- While there are some good services for children and young people not all of those who need extra help get it as soon as they need it.
- Where there are serious worries about a child, social workers act quickly to help make children safe.
- Social workers spend time talking to children and young people to understand what they need to do to help them but too many children have had lots of changes of social worker. The local authority knows this is hard for children and managers are working to make sure that they have enough permanent staff so that social workers do not change so often.
- Young people, parents, social workers, teachers, police officers and other professionals have all been given lots of information about how to help keep children and young people safe from sexual exploitation. Managers need to do more to make sure they keep track of this work.
- Until very recently, when children went missing they were not always given a chance to talk to an adult, when they returned, about why they ran away. This means professionals did not always know how to help keep them safe.
- There are not enough foster carers living in Wiltshire. This means that not all children cared for by the local authority live near to their friends and families. Children and young people who are cared for by the local authority get good support for their emotional and mental health needs.
- Care leavers who spoke to inspectors said they feel safe but not all of them are fully involved in making plans for their future or properly understand what the plans for them are.
- Social workers work hard to find adoptive families for children who need them and more children are now moving to live with an adoptive family. Some children wait too long before moving to live with their new families.
- Children and young people's views are important to the local authority. They have listened to children and as a result have made changes to the way they do things. The Children in Care Council works well with the local authority. The shared guardianship meetings help the council understand what is important for the young people they care for.
- The local authority knows what it is good at and what it needs to do to improve services for children and young people.

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

Summary

Senior managers and leaders have taken, and continue to take, decisive and effective action to create a stable workforce, strengthen management oversight, establish effective partnerships with other agencies and drive up practice standards. The variable quality of early help work and the reluctance of some partners to take on the lead professional role mean that children do not always get the right help and support at the right time. Some partners do not understand the threshold criteria for access to children's social care.

Decisions taken in the Multi-Agency Safeguarding Hub (MASH) are appropriate. Immediate risk to children receives a prompt and effective response. The way in which child protection strategy meetings are organised is an area of real strength. The rate of re-referrals following a step-down from children's social care has reduced.

In the absence of a permanent and stable workforce, practice standards have suffered. In some teams, repeated changes of social worker have made it difficult for some children to form meaningful relationships with them and have contributed to drift and delay in implementing plans. Until recently, management oversight by some team and assistant team managers has been poor. While social workers feel well supported by managers who are accessible and are now receiving regular supervision, this is generally task-focused, is rarely reflective and does not consistently address workers' professional development.

The quality of assessments is variable; weakness of analysis is a common feature of those that require improvement. Social workers do not always make effective use of chronologies to understand children's and families' histories. Families are well supported by a range of services where domestic abuse is an issue.

Child protection plans are outcome-focused, specific and measurable but are not always easy to understand. Some plans are too adult-focused. Child in need plans are not always regularly reviewed and in some teams some children in need do not have a plan. Senior managers are taking action to strengthen step-down arrangements from children's social care to early help. The arrangements for the management of allegations by the designated officer have recently improved.

The vast majority of children who go missing are now offered missing return interviews (MRIs). However, while information and intelligence from MRIs is used to safeguard individual children it is not systematically collated and analysed to inform the Wiltshire profile and to date the local authority has not been effectively monitoring the use of the child sexual exploitation screening tool.

Inspection findings

12. Although early help is not yet fully developed, partners understand and are committed to the new early help strategy, the direction of travel and the way in which the strategy is being implemented. Coordination has been strengthened through the creation of a number of early help officer posts within the local authority, designed to improve communication and oversight of early help work. However, these changes are new and it is too soon to evaluate their impact on outcomes for children.

13. Children's centres provide a good range of services, have extensive reach and work well to provide help and support to children and families. Outreach workers, all of whom are trained in the local authority's domestic abuse support approach, are effective in responding to the needs of families and are making a positive difference. For example, the rate of re-referrals following a step-down from children's social care has reduced.

14. Locality-based multi-agency forums (MAFs) are increasingly effective in sharing information and ideas, exploring problems and mobilising support for families when problems first emerge. The countywide Gateway Panel is effective in matching children and families with services that are most likely to be able to help them. This includes referral to the Wiltshire Families First programme, which has had considerable success in turning around troubled families. These arrangements have also contributed to the reduction in re-referrals following a step-down from children's social care.

15. The quality of early help varies and it is not consistently used to best effect to improve outcomes for children and young people. While some early help assessments are good, especially those completed recently, some lack sufficient analysis and early help plans are not always sufficiently outcome-focused, specific or measurable.

16. A lack of confidence and resilience, together with a historical reluctance by some partners to take on the lead professional role, means that children and families do not always get the right help at the right time. The number of referrals to children's social care that are appropriately re-directed to early help or closed at the point of referral also demonstrates that some partners do not fully understand the threshold criteria for access to social care services.

17. The MASH has a positive impact in ensuring that the threshold criteria for access to social care services are applied consistently. Information is shared appropriately. The issue of parental consent is taken seriously and routinely sought. Social workers effectively filter, assess and analyse information in order to identify risks and strengths before making a recommendation about the level of intervention required. Good management oversight and appropriate checks and balances ensure that decision-making is appropriate.

18. Headteachers and other professionals are able to seek advice and guidance from the MASH on a 'no names' basis. Arrangements are robust and queries are escalated to social workers appropriately. Until recently there was a backlog of outcome letters waiting to be sent to referrers confirming the action taken in response to their concerns. This has now been remedied following more effective management scrutiny and decision making. An education liaison officer has recently joined the MASH and ensures information from schools and colleges is shared effectively to support assessments and planning.

19. When safeguarding issues and concerns are first identified the response is timely. Strategy discussions are effective, appropriately attended, well-chaired and the recording of decisions is clear. A dedicated team of minute-takers means that decisions taken and actions agreed are circulated promptly ensuring that section 47 investigations are timely, well-informed and thorough.

20. The emergency duty team provides an effective service for children and families at evenings and weekends. Safeguarding arrangements for children with disabilities are well understood, implemented and effective with robust examples seen by inspectors.

21. In most cases, children are seen and seen alone. Social workers use a range of communication and other tools to engage children and ascertain their wishes and feelings. However, the high turnover of staff in some teams has made it difficult for children and families to build meaningful relationships with their social worker. In some cases, this has contributed to drift and delay in implementing plans. While caseloads are reducing and the average is now 24, some social workers' caseloads continue to be high at up to 33 children.

22. The quality of assessments is variable, ranging from requires improvement to good. Immediate risks are identified and social workers clearly recognise significant harm. However, in some cases, the way in which risks and strengths are described is not sufficiently explicit or succinct and less acute risks are not always fully explored. Inspectors saw a small number of assessments that had either not been completed or were significantly delayed and not sufficiently analytical and this did not enable risk to children to be assessed in a timely manner.

23. While social workers do take account of previous involvement with children and families, they are not making good or effective use of chronologies to get a full picture of the child's experience. This has adversely affected the local authority's response, and that of its partners, in some cases of child neglect. In a small number of cases seen, there was evidence of a failure to recognise the cumulative impact of emotional harm and neglect and identify disguised compliance of parents early enough. This has now been rectified and more recent casework is robust and purposeful. The Wiltshire Safeguarding Children Board (WSCB) is in the process of developing risk assessment tools to strengthen and improve multi-agency recognition of, and response to, neglect.

24. The quality of child protection plans is variable. The majority are outcome-focused, specific and measurable but almost half of the plans seen by inspectors were not sufficiently child-focused. This adversely affects the core group's ability to evaluate whether risks to specific children are reducing. A minority of plans were not sufficiently explicit to enable parents, carers and children to easily understand expectations of them. There was limited evidence of well-developed contingency planning.

25. Good partner engagement and participation in child protection conferences ensures that they are effective forums for professionals to share information and assess levels of risk and need. Most are well chaired and parents report that they feel involved and included. Where appropriate, conference chairs escalate issues and concerns about practice, and this is followed up by senior managers. However, some review child protection conferences are not held on time which means that progress in reducing risks is not evaluated soon enough.

26. Child in need planning requires improvement. In the two teams significantly affected by high levels of staff turnover, a small minority of children do not have a formal, written child in need plan and while these children's needs have been met, this has not been achieved through a well-coordinated plan. Others have plans that are not regularly reviewed. Rigorous scrutiny by senior managers, involving a recent review of all open child in need cases in those teams, provides assurance that children are not being exposed to significant harm. The performance of these teams is closely monitored and recent casework has significantly improved, leading to better outcomes for children and young people.

27. In response to a recent audit which showed that social workers were not consistently following step-down procedures from children's social care to early help, the local authority is in the process of setting up a number of step-down panels, beginning in the north of the county. The north panel coordinates and monitors step-down arrangements and provides consistency of decision making. Senior managers plan to roll out that approach across the county to ensure that, as problems recede, children and families continue to get the right help and support.

28. While the vast majority of social workers now receive regular, monthly supervision, it is generally task-focused. There is little evidence of reflective supervision. In a small number of cases, until a very recent improvement in management intervention, a lack of rigorous and robust management oversight led to drift and delay in meeting children's needs.

29. Fortnightly Multi-agency Risk Assessment Conference (MARAC) meetings are effective in sharing information, identifying risks and developing appropriate protective responses for those children and victims affected by domestic abuse. However, while children's social care is fully involved, not all key partners are fully engaged. Multi-agency public protection arrangements (MAPPA) work well.

30. Social workers make good use of a range of services to support families where domestic abuse is an issue. For example, male perpetrators of abuse are engaged in programmes to tackle their abusive behaviour, and children who have witnessed domestic abuse are well supported. Inspectors saw examples of decisive and effective intervention in families where parental mental health problems were having a damaging effect on children and young people. Approximately 89% of children and young people with emerging mental health problems are now seen by Child and Adolescent Mental Health Services (CAMHS) within 12 weeks. Although this is an improving picture it means that some young people have to wait too long for this service.

31. Young people now receive a timely and effective response to their need for protection from sexual exploitation. The local authority's child sexual exploitation strategy action plan was signed off in May 2015. While a child sexual exploitation manager has been appointed, two specialist social workers have yet to take up their posts. Currently, the local authority does not have a systematic way of monitoring the use of the child sexual exploitation screening tool, or evaluating its impact on referrals. However, the screening tool, which is about to be reissued, has now been revised in order to make it simpler and easier to use and the MASH referral form has been amended to include a specific question about sexual exploitation. In 2014, 111 young people were identified as being potentially vulnerable.

32. The Wiltshire Risk Management Group is well-embedded and effective in monitoring risks and coordinating multi-agency responses to the most vulnerable children and young people, including those who are at risk of radicalisation. Inspectors saw evidence of well-coordinated multi-agency responses to child sexual exploitation, for example in the case of children in care who are living in Wiltshire having been placed there by other local authorities.

33. Although the form and content of the monthly missing children and child sexual exploitation reports have improved significantly over the last four months, there is still a discrepancy between the number of missing incidents, the percentage of missing return interviews offered and the percentage of those completed. The fact that completion rates are calculated against offer rates, as opposed to missing episodes, is unhelpful. Information about children who are missing from home or care, or at risk of child sexual exploitation, is not sufficiently closely aligned to information about children who are absent from school. Information and intelligence gathered from missing return interviews are not yet being systematically collated and analysed. However, the local authority's own figures show that, in June 2015, 90% of missing episodes resulted in the young person being offered a missing return interview.

34. The local authority has effective arrangements in place to identify and monitor children who are missing education. They are currently working with 56 active cases.

35. Oversight of elective home education is good. The local authority keeps clear and detailed records of the 355 children who are currently electively home educated and works effectively with families. The local authority works well to ensure that most children in alternative education receive at least 25 hours of education per week and those who do not are all working towards the target of 25 hours per week.

36. Despite a range of initiatives designed to raise awareness and increase reporting, the number of private fostering arrangements is low. Ten children are currently living in private fostering arrangements and receive effective support. The local authority has effectively assessed the children and their carers to ensure private fostering placements are appropriate and safe. The local authority works well with local language schools to ensure that assessments of arrangements are completed and visits undertaken with children and their carers in a timely manner. This has resulted in the identification of a further 22 private fostering arrangements. Performance in relation to known private fostering arrangements is variable; in 2014–15 100% of statutory six-weekly visits to children living in private fostering arrangements were completed on time but only 41% of initial notifications were responded to within timescales. Not all practitioners understand the criteria that defines a private fostering arrangement.

37. Arrangements to support 16- and 17-year-olds who present as homeless are effective and well monitored. Good quality supported accommodation is available to young people and this work is underpinned by a robust and well implemented working protocol between the local authority, local housing charities and the Wiltshire Accommodation Service. Young people are well supported by children's social care following timely assessments of need. However, case sampling demonstrated that joint assessments with housing are not completed in every case.

38. Inspectors identified weaknesses in the arrangements for managing allegations against adults who work or volunteer with children and young people although this was not seen to place children at risk. This issue had been identified by the local authority and a plan recently developed to tackle them, although this work had not begun. During the inspection, senior managers took immediate action to strengthen arrangements. Action included the implementation of improvements in the recording of casework, as well as ensuring authorisation for appropriate staff to access the allegations management database. Additionally, the local authority has identified lessons learnt and this has resulted in improved practice such as circulating information on allegations management arrangements to local faith groups.

39. The complaints leaflet is not child-friendly or effectively promoted to children and young people. Very few children take advantage of the advocacy support available to them should they wish to complain. They are, however, making good use of advocacy support to express their thoughts, wishes and feelings as

part of the child protection conference process. The local authority is taking account of, and acting on, feedback from children and families.

40. Equality and diversity are not always considered or addressed in assessments and direct work with families, the exception being children with disabilities. Parents and carers of children with disabilities have access to good quality information about services and sources of support. Staff within the children with disabilities teams work in a very child- and person-centred way.

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

Summary

Outcomes for children in care are not yet good in Wiltshire. The pace of improvement, following an earlier Ofsted inspection in 2012, which identified some similar areas for improvement, has been slower. The service has only recently commenced implementing essential improvements, particularly in permanence planning, the sufficiency of local placements and the response to children in care who go missing. The impact of recent improvements is not yet demonstrated.

The Public Law Outline is used effectively. Decisions to take children into care are appropriate. However, in a small number of cases, proceedings involving children cared for under a voluntary arrangement were initiated too late, thus delaying subsequent permanence planning for children.

While social workers know children in care well, the experience of children in the last 12 months has been variable. While most have enjoyed consistent, high quality foster placements and benefited from sustained relationships with foster carers and social workers, some children have experienced an inconsistent approach to securing permanent homes for them. Comparatively more children in care in Wiltshire are looked after on a long term basis under voluntary arrangements than the national average. The response to children in care who go missing has, until very recently, been limited, with a large majority of children not being offered return interviews.

Children in care did not do as well academically in 2013/14 as in previous years. The proportion of children making expected progress during secondary school was much lower than the average for children in care nationally, and attainment gaps between children in care and all children in the county have increased.

While there are good elements to the service being provided to care leavers, the quality of pathway plans is not consistent. While the vast majority of care leavers are effectively supported and monitored, they are not provided with information about their health histories and entitlements. Young people spoken to by inspectors reported that they feel safe in their accommodation. Robust arrangements are in place to support young people to begin their transition to independence early.

While the local authority adoption performance is better than that of comparators, performance has deteriorated in the last year. The timeliness for placing children for adoption from care, while improving, is slower than national timescales. Recent senior management scrutiny and review of adoption practice evidences an understanding and knowledge of where improvements in permanence planning and matching need to be put in place but progress has not been fully demonstrated. The Children in Care Council exercises demonstrable influence on the development and delivery of services.

Inspection findings

41. Children and young people now enter care when they need to and this is a significant improvement since the last inspection. The rate of children in care in Wiltshire is below comparators, although rates have remained constant over the last three years. At the time of the inspection, 414 children were in the care of the local authority. Decisions to look after children and young people are mostly timely and appropriate. Decision-making by the edge of care panel is careful and considered, with children and families receiving intensive multi-disciplinary interventions to reduce risks and prevent entry to care where appropriate.

42. Having recently undergone a peer review of children in care services, the local authority is in the process of developing a looked after commissioning strategy and a placements marketing development plan to address identified weaknesses. Senior and middle management arrangements have been strengthened and this is leading to improvements in relation to a legacy of inconsistent permanence planning, placement sufficiency, care planning and reviewing for children in care.

43. The Children in Care Council exercises demonstrable influence, both in reviewing provision and in proposing innovations which are closely considered at 'shared guardianship' meetings with the Corporate Parenting Panel (CPP) which are chaired by young people. A strong vein of accountability to young people is evident through 'You Said, We Did' responses and other mechanisms. The Children In Care Council has contributed to information leaflets for children in care as well as to services for children with disabilities and this has led to improved advocacy arrangements.

44. The timeliness of care proceedings has continually improved and is now 24 weeks. In the vast majority of cases the Public Law Outline is used well to ensure timely improvements are achieved, where possible, for children living in families with a high level safeguarding concerns. However, a small minority of children are cared for voluntarily with inappropriate parental agreements where care proceedings should have been issued earlier. This has delayed subsequent permanence planning for those children who did not return to their parents' care.

45. The quality of evidence presented by social workers within care proceedings is good, with very few additional assessments requested by the courts. The Wiltshire specialist assessment team produces authoritative parenting assessments, particularly of parents with learning difficulties, which are highly regarded by the judiciary. The quality and timeliness of viability assessments of extended family members are reliably good.

46. A majority of plans seen by inspectors for children in care who return home evidenced work with parents to evaluate whether originating concerns had been addressed and reduced. However, clear, time-bound plans setting out work prior to and following their return home were not always apparent. Few

children in care were placed at home in 2014–15 (2% of the total). Wiltshire's rate of children who ceased to be looked after in 2014–15 was also below other local authorities. Management information made available to inspectors did not demonstrate that managers had analysed the reasons for these low numbers. As a result this has hampered managers' ability to assess whether reunification of parents and children is considered in all appropriate cases.

47. The percentage of Wiltshire's children in care who are cared for under a voluntary arrangement under section 20 of the Children Act 1989 (34%) is lower than the statistical neighbour (38%) but higher than the national average (28%). Half of these children have been looked after for over a year. Correspondingly fewer children in care are the subjects of interim care orders. A significant number of children in care in Wiltshire (60 or 14% of the total population of children in care) do not have legal permanence arrangements, particularly approved long-term fostering or care order applications where a legal order would be in their best long-term interests. The effectiveness of management scrutiny and oversight has increased very recently, but a minority of children in care lack certainty about their futures.

48. Since 2011 the number of children leaving care through a Special Guardianship Order (SGO) has increased year on year from five in 2011–12 to 30 in 2013–14, demonstrating Wiltshire's effective permanence planning for this cohort of children. The number reported for 2014–15 is 25, a slight decrease. However, the number of children leaving care through SGOs at 16% in 2013–14 was higher than comparator averages of 10% and 11%. Special guardianship arrangements are based on good quality assessments and carers are well supported.

49. Of those children in care, 28% live more than 20 miles from their home communities. Placement sufficiency is the primary factor limiting the availability of local placements. A longstanding management objective to increase the number of local Wiltshire foster carers remains unrealised. Wiltshire is providing foster placements through independent fostering agencies, purchased through a regional commissioning framework that does not supply enough local placements. Moving to these placements means that many children experience changes in schooling and difficulties in maintaining contact with friends and families. Of those 118 children who live in distant placements, 73 live outside Wiltshire, creating additional complexities in the arrangement of effective health and educational provision from host local authorities. Only 34 of 118 children in distant placements have an advocate. This is concerning in a context where children's access to local professional and family networks is more limited.

50. A large majority (78%) of children in care in Wiltshire who had single or multiple missing episodes between June 2014 and May 2015 were not offered missing return interviews. More recently the local authority has taken effective action to ensure that all children are now offered return interviews making it possible to analyse and collate findings from them to reduce both individual and

collective risk. The impact of the new arrangements cannot yet be fully demonstrated.

51. While practice in some individual cases is sound, strategic coordination of the sexual exploitation response was slow to be implemented. While a child sexual exploitation screening tool has been in use since 2014, the lack of completed missing return interviews in some cases indicates that any associated risks of child sexual exploitation may not be identified or addressed. However, in cases seen by inspectors, the risks of child sexual exploitation, missing episodes and substance misuse were effectively addressed, including children placed out of county and distant placements within Wiltshire's borders.

52. In the last year only 4% of children in care in Wiltshire committed offences, with none in custody or secure institutions. An effective multi-disciplinary panel meets regularly to track and reduce offending behaviours. Proportionately slightly more children in care in Wiltshire than in other local authorities have an identified substance misuse difficulty. While the numbers of young people involved is 15 and this is low, effective arrangements are in place to support them.

53. Children in care did not do as well academically in 2013/14 as in previous years, where the outcomes were broadly in line with the low national averages for children in care. For example, progress between Key Stage 2 and Key Stage 4 is well below the national average for all children in care. The proportion of children making expected progress during secondary school was much lower than the national average for children in care nationally, and attainment gaps between children in care and all children in the county increased. However, the virtual school has analysed the reasons and school data predict that outcomes for 2014/15 will rise again. For example, the proportion of children in care who got five good GCSEs in 2013/14 was 11%. Predictions are that this will rise to 20% in 2014/15 following well targeted intervention. While this is an improvement, performance remains low.

54. The local authority has developed well the work of the virtual school and increased the number of staff. Eight virtual schools officers work effectively with schools and with individual children in care and improvements in the virtual school are being sustained. The large majority of personal education plans are good, with detailed assessment and analysis, which staff use well to help individual children in care. A small number of the cases sampled require improvement in that they do not contain sufficient detail to identify progress and plans to meet individual children's needs and aspirations.

55. Virtual school staff closely monitor the use and impact of pupil premium funding. Schools are required to bit for this funding, in line with government guidelines, and the virtual school uses funding effectively, for the benefit of children in care generally. The local authority has worked well to improve the attendance of children in care, from a poor level to performance that is broadly in line with the national average for all children. The rate of unauthorised

absences for children in care is lower than that nationally. The local authority has been effective in increasing the proportion of children in care and care leavers who are in education, employment or training from 62% in 2013 to 82% in 2015.

56. The local authority does not use data sufficiently to analyse performance overall. For example, for those Wiltshire children in care educated within the county the proportion making expected progress is 8% higher than for those educated outside the county, but the local authority had not identified this. In addition, while the local authority records the destinations of children in care when they leave school at age 16, it does not record their progress and attainment on their post-16 programmes.

57. The large majority (91%) of annual health assessments for children in care are completed in line within required timescales. A majority of initial health assessments (61%) are completed within 28 days, which is comparable with performance elsewhere although requires further improvement. Careful attention to monitoring and improving the physical health of children in care was apparent in the majority of cases seen by inspectors, including those in distant placements. The early identification of initial health needs of a small number of unaccompanied asylum-seekers was assisted by the routine use of interpreters. All first health reviews for children in care were completed within three months.

58. Children in care are offered effective emotional and mental health support through a blend of CAMHS provision. Therapeutic support to foster carers, kinship carers, special guardians and adopters is provided through the family placement service by seconded CAMHS staff. Up to 44 families have received this service, which provides specialist support and strategies to help manage the difficult behaviour of some children in care, assisting in the prevention of placement breakdowns. This support is an important factor in the relatively low number of moves for children in care in Wiltshire, despite the limited sufficiency of foster care placements. Referrals to the service are managed promptly with 92% of referrals responded to within 10 working days. CAMHS also provides direct outreach support to 34 children in care, including an offer of out of hours interventions.

59. Social workers know children in care well and caseloads in the long-term looked after teams, where 75% of children in care are allocated, have reduced considerably over the previous year and are now manageable. The quality of case recording seen by inspectors was mostly good, with clear accounts of children's views, concerns and wishes. Case recordings addressed key outcome improvement areas such as education and the quality of attachments with carers, but did not consistently report how outcomes were progressing between regular statutory visits.

60. In the large majority of cases seen during the inspection, contact arrangements with family members were carefully documented and reviewed to ensure they

were balanced and beneficial for children. Contact meetings were arranged to minimise disruption to the daily routine of children in care, although inconvenience was inevitably greater for the considerable number of children in distant placements.

61. Life story work is sensitively undertaken in a timely manner for children in care with a plan for permanence. This work is completed by social workers who know their children well and foster carers are well engaged in this process. Life story books and memory boxes are well used to ensure children's memories are preserved and well recorded for the future.

62. Attention to diversity and difference for children in care was evident, but generally too superficially explored, particularly in relation to emerging sexual identity and the formation of positive gender, racial and ethnic identities.

63. Children in care have access to a range of sports, clubs and leisure facilities, encouraged by their carers and documented in their case records. Additionally, the 'Aspire' centre provides a dedicated resource for children in care in Wiltshire, housed in a pleasant building offering further educational support by the virtual school, an IT suite, activities, groups and a meeting venue for the Children in Care Council.

64. The review and updating of single assessments for children in care is improving and this is contributing to the development of more informed care plans. A majority of care plans contained clear outcomes, refreshed following children in care reviews with specific time-bound actions. A minority of single assessments and care plans were not updated within statutory timescales and were insufficiently focused on evaluating children's progress over the preceding year.

65. Independent Reviewing Officers (IROs) hold comparatively manageable caseloads of 60 to 70 children. Some looked after children reviews are not completed within statutory timescales. However, recent improvements in recording mean that at the time of the inspection 89% were completed on time compared with 44% in January 2015. The majority of review minutes are not written or circulated within 20 working days, with some examples of protracted delays seen by inspectors. The implementation of permanence plans for some children in care is adversely affected by this lack of timeliness. Evidence of IROs meeting children before their looked after reviews, and monitoring the progress of review recommendations and care plans between reviews, was apparent in a minority of cases seen, but was not consistently evident for the majority of children and is likely to be a further factor in delayed permanence planning. There were determined efforts by IROs to improve their influence in the formation of robust care plans in care proceedings, illustrated through more effective liaison with the Children and Family Court Advisory and Support Service (Cafcass).

66. Cases of children in care, sampled by inspectors in Wiltshire's fostering service, demonstrate that regular visits to carers by supervising social workers, including unannounced visits, take place to monitor placement arrangements.

67. Annual reviews of foster carers are independently chaired with thorough, focused attention on obtaining meaningful contributions from children in care. Training provision for carers is regular and comprehensive. The majority of foster carers have completed their initial training and development standards.

68. Delegated authority to foster carers was not well recorded in cases seen by inspectors, and placement plans contained information that was too basic to provide carers with the necessary background knowledge of children they were starting to look after.

69. Foster carers spoken to by inspectors appreciated the support and availability of their supervising social workers, family placement therapeutic staff and the virtual school. The service has undergone a net loss of foster carers recently, primarily through a management review of those who were offering few or no placements. The service has set ambitious recruitment targets, led by a new manager, to increase considerably the number of in-house foster carers recruited annually, gradually reducing the disproportionate number of distant placements.

70. The fostering panel is independently chaired with a diverse central list of experienced members and decision making is robust and clear. The quality of assessments of prospective foster carers is good and ensures children are placed with carers whose skills and expertise have been well identified and evaluated. Careful efforts are made to place brothers and sisters together and exemptions are appropriately sought to enable this.

The graded judgement for adoption performance is that it requires improvement.

71. Wiltshire considers adoption for all children who are unable to return to their birth families and who need a permanent alternative home. However, children are not always placed for adoption in a timely way. From 2011 to 2014 Wiltshire performance for the average time between a child entering care and moving in with its adoptive family was 637 days. This is 90 days longer than the national target of 547 days. For 2012–15 it was 602 days, which was 115 days longer than the national target of 487 days. For 2015–16 the provisional figure is 578 days, which will be 152 days longer than the national target of 426 days. Compared with statistical neighbours, in 2013–14, Wiltshire was the third lowest performer, indicating that children wait too long before being placed with adopters. While Wiltshire is missing the target by more in each three-year cycle, the average number of days taken has reduced year on year.

72. Family finding arrangements for the vast majority of children are timely and result in effective matching with carers. A small number of children experience delay in being matched with a family. Clear plans are in place for these children. However, they have not been sufficiently well driven and waiting times range from 33 to 88 days from the making of the placement order. The local authority has identified that family finding plans are not always effectively driven and has recently increased the management oversight and scrutiny to reduce delays for children.

73. There are effective arrangements in place to ensure that key staff members are aware of all children who may require adoption, so that it is considered in the early stages of children's care planning. Permanence planning arrangements have been the subject of well-targeted management scrutiny and this has led to a drive to improve performance and to minimise delay for children.

74. Twin tracking or parallel planning processes for children with an adoption care plan were variable, with some cases evidencing a linear approach, where one plan is followed and concluded before other alternative plans are actioned. However, practice has recently improved following well targeted management scrutiny and purposeful oversight. While tracking and monitoring processes are now in place for children requiring adoption, to improve timeliness of placements, the impact of this is not yet fully embedded. In 2014–15, only two foster-to-adopt cases and no concurrent placements were made. The local authority has identified this as an area for development and is now effectively considering these arrangements for children where this is appropriate.

75. Child permanence reports are comprehensive, with sensitive and thorough information about the child's needs and history, a thorough assessment and the reasons the birth family is unable to care for the child. These reports ensure that children's needs are effectively identified and considered and used appropriately for matching considerations. The process for family finding and matching with adopters is not always sufficiently purposeful or well driven. For example, on occasions individual profiles are not circulated in a timely way, leading to delay in children being matched and placed.

76. Arrangements to review whether adoption is the most appropriate plan are effective and well-targeted. For example, 12 children had adoption care plans appropriately rescinded between April 2014 and March 2015 because adoption was no longer the appropriate plan. Scrutiny of these cases reflects clarity of planning and robust assessments that have contributed to appropriate decisions not to pursue adoption plans.

77. Adoption performance information is not comprehensive. Significant gaps in key data include the lack of assessment timeframes for adopters as well as the numbers of children from a minority ethnic background who are adopted. This does not provide the adoption service or senior managers with accurate information to complete a strategic analysis and assess overall performance.

While the authority has identified this as a key area for development, action taken to address it is very recent and has not yet had an impact on children.

78. Performance in Wiltshire is broadly in line with comparators for the average time between a local authority receiving court authority to place a child and the local authority deciding on a matching adoptive family. However, performance is variable and not consistently improving. In 2012–15, the national target was 121 days and Wiltshire's performance was 148 days. The national target is set at 121 days for 2013–16 and the provisional Wiltshire performance is estimated at 151 days. The local authority has, however, recently strengthened arrangements to identify families at an earlier stage and ensure delays are avoided.

79. Adopters are prepared and assessed well and are given opportunities and training to understand the reality of adoption and the needs of the children who may be placed with them. The quality of assessment work sampled was good, identifying the adopter's strengths and weaknesses with appropriate analysis of what they could provide for a child, and was compliant with regulatory standards. This enables the adoption service to make well informed and well matched placements that will be clearly able to meet the needs of the children placed.

80. Adopter recruitment has been appropriately targeted in the last year to meet the more complex needs of the children waiting for adoption, although some of the adopters recruited in 2013–14 in response to the national drive to recruit have very limiting requirements for the children they are willing to be matched with. As a result some prospective adopters are still waiting for children to be matched with them. The service has placed four sets of brother and sister groups appropriately, and only separates siblings where it is in their best interests. Sensitive and appropriate matching of cultural and ethnic needs as well as placements with same sex couples demonstrate that the service actively considers who is best placed to meet children's needs.

81. Some adopters were not assessed and approved within national timescales. A small minority of adopters had not been referred to the national adoption register, leading to unnecessary delays in being matched with children waiting nationally. All adopters were referred to the South West Adoption Consortium.

82. The adoption panel and agency decision maker ensure that children are effectively matched with the most appropriate families. The adoption panel is well run and managed and promotes good practice through its work. The chair is very experienced in adoption work, providing helpful insight to the adoption agency decision makers and managers on a quarterly basis about issues arising from work presented to the panel. The agency decision makers were seen to provide appropriate decisions, and have taken action to improve timeliness in relation to 'should be placed for adoption' decisions so that family finding for some children can start earlier.

83. Adoption support team statistics identify that a wide range of post-adoption help was provided to adopters and special guardians in 2014–15. In addition to support groups, three annual social events and on-going training, the team coordinated 369 post box exchanges, and 597 helpline contacts were taken. There were 58 referrals for adoption support services, all of which were progressed. There is currently a waiting list of 16 adopters and five special guardians waiting for an assessment of need, due to a higher volume of referrals and staff absence. There are appropriate plans in place to manage this.

84. The adoption support team is effective, innovative and forward looking and is improving its offer to families who require more intensive support. It is appropriately using the adoption support fund and providing support for six families with child on parent violence. Feedback from adopters was positive, particularly about the family placement therapeutic service, adopters support groups and assistance with life story work. Two disruptions in 2014–15 were dealt with appropriately and lessons learnt were effectively disseminated across the service.

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

85. Since last September the local authority has adopted a more rigorous approach to keeping in touch with care leavers. The vast majority of the 204 care leavers are now effectively supported and monitored. However, the local authority has chosen to close the cases of 10 care leavers (5%) whom they consider to be settled and no longer to want or need a service, rather than maintain periodic written contact with them.

86. Young people spoken to by inspectors reported that they feel safe in their accommodation and that they have had some choice in where they are currently living. Young people who go missing are routinely identified and receive a timely response to their needs for protection. Care leavers report that the local authority keeps track of them when they go missing and they are reassured by the level of support they receive from personal advisors. Personal advisers are alert to risks in relation to child sexual exploitation and those at risk are supported effectively. Risks are identified in a timely way and thoroughly assessed, with plans and interventions leading to reduced risk and increased resilience. Inspectors saw effective work being undertaken both to reduce offending and to rehabilitate care leavers into the community after periods in custody. There are currently two care leavers in custody, with the local authority reporting a comparatively low offending rate of 3% among its care leaver group.

87. Robust arrangements are in place to support young people to begin their transition to independence early. Personal advisors are allocated alongside

social workers to work with 16- and 17-year-olds, focusing particularly on independence skills. Young people are benefiting from a range of life skills training; for example, budgeting and cookery sessions are provided by their personal adviser. Additionally, the local authority commissions the services of a semi-independent accommodation provider who has three sites across Wiltshire. This service undertakes needs-assessed independence skills training with young people, eventually assisting them to apply for their own independent accommodation.

88. While pathway plans are mostly completed in a timely way, their quality is inconsistent and this limits the extent to which they are able to impact positively on the lives of young people. The majority of plans lack analysis, do not thoroughly consider identity and are not specific regarding action to be taken, by when and by whom. The pathway planning process is cumbersome and frequently duplicates work. Arrangements for reviewing pathway plans are not reliable, and do not consistently involve the young person and the wider network. Young people spoken to during the inspection reported not feeling well engaged in their pathway plan.

89. Arrangements to ensure that care leavers' health needs are met are generally good. Designated looked after children nurses have good links with the leaving care teams, providing support and guidance to young people and personal advisors about how to access relevant community services. Effective arrangements are in place for young people with mental health needs to make the transition to adult services without disruption. Arrangements to support young people who experience drug and alcohol problems are well developed. However, care leavers do not currently have access to their health histories and this limits their ability to make informed decisions about their health requirements. The local authority has plans to address this.

90. Performance on suitable accommodation for care leavers is good at 81%. Young people are risk assessed and closely monitored in their accommodation. There is a range of accommodation to meet the diverse needs of care leavers in Wiltshire. Securing placements close to where the young person has links, for young mothers and for young people with disruptive behaviour, remains a challenge to the local authority, which has responded by spot purchasing timely bespoke packages of care when required.

91. The local authority has a policy of not using bed and breakfast accommodation, even in an emergency, with no young people placed in this type of accommodation over the last year. There are currently no young people placed in multiple-occupancy housing. Effective commissioning arrangements for care leavers are in place to ensure that this is consistently achieved and that care leavers can enjoy both suitable accommodation as well as some degree of choice.

92. Currently, there are 10 young people being supported to remain with their foster carers. These arrangements have been individually negotiated in each

case. The local authority's strategic arrangements to support such opportunities for all care leavers have only recently been introduced through a Staying Put policy

93. The local authority has worked hard to increase the number of 19–21 year olds in education, employment and training, which has increased from 35% in 2014 to 50% in 2015. This is now better than comparators (41%) and the national average (45%). This work is effectively driven by the virtual school, which has two workers with a post-16 specialisation who have strong links with colleges and employers. As of 31 May 2015, 18 care leavers are attending university, representing 11% of care leavers, which is higher than the national average of 6%. Ninety-eight care leavers are in college; and 79 are in employment and training, of whom nine are in apprenticeships with the local authority. Young people who are at university reported that they feel well supported.

94. Care leavers are not appropriately made aware of their entitlements and young people spoken with during the inspection did not get information about what the local authority should be providing them with. However, the Children in Care Council has recently developed a leaflet clearly setting out the support which is available to care leavers, including a leaving care grant of £2,000, but this has not yet been systematically shared with young people.

Leadership, management and governance	Requires improvement

Summary

Improvement since the 2012 inspection was focused on child protection and the 2013 inspection noted that the pace of change and improvement in other areas of the service had been slower. In the last 12–18 months, the local authority has made determined efforts to improve services for children and young people and these have been well driven and purposeful. Elected members and senior managers are informed and knowledgeable about the quality of services children and families receive and there is clear political support to the Children's Services Leadership Team (CSLT). Wiltshire operates a tri-partite arrangement to perform the function of Chief Executive, with this role shared between the Director of Children's Services (DCS) and two other corporate directors.

The senior leadership team now has a comprehensive overview of the strengths and weaknesses across the service. The ability of the senior leaders to drive improvements and embed consistent good practice has been adversely affected by the challenges in recruiting experienced permanent social workers and managers across the service. Staff at all levels have now been appointed, reaping improvements in practice as well as effective and decisive leadership and drive. Senior leaders are ambitious and, while they acknowledge that their focus has been on safeguarding services, improvements to children in care services are now also evident. Senior managers and leaders have taken, and continue to take, decisive and effective action to establish constructive partnerships with other agencies.

The re-configuration of services, level of financial investment and increased size and stability of the workforce have led to improvements in the timeliness and quality of the services children and young people receive. Improvements are not yet consistently established across all areas of service and, in some instances, where improvements have been made, these are very recent and not yet having an impact on improving outcomes for children and young people. Senior leaders are aware there is more to do and recognise the areas for improvement identified in this inspection.

Management oversight of casework is improving and staff have recently experienced more consistent, effective supervision. While average caseloads of 24 continue to be higher than the target of 18 that senior managers are striving for, these are reducing. Social workers feel well supported by visible leaders who visit social work teams regularly to understand the challenges faced by social workers.

Performance management processes are limited, although this is currently a key priority for the local authority. Quality assurance and scrutiny arrangements have significantly improved recently and are now finding improvements in casework and outcomes for children and young people.

Senior leaders are demonstrably committed to the needs of children in care in

Wiltshire and corporate parenting is developing. Arrangements to engage children and young people and to enable them to contribute to service development and planning are improving.

Inspection findings

95. Governance arrangements are robust. The arrangement whereby the DCS also performs the role of Chief Executive on a rotating basis with the two other Corporate Directors has been subjected to an independent scrutiny both by a Local Government Association peer review and an independently commissioned auditor. Both reviews found the arrangement to be satisfactory and to meet statutory functions. While this arrangement is unusual, it has facilitated an increased profile and understanding of children's services at corporate director level.

96. Corporate directors are knowledgeable about the challenges facing the service and responsive in identifying solutions and resources. One example is in relation to the funding of social work bursaries from the public health budget, for the 'grow your own' social worker scheme. This will be rolled out in the autumn through the newly established Wiltshire Institute for Health and Social Care (WISC). Corporate directors working with the DCS conduct annual appraisals of the independent chair of the LSCB.

97. There are clear lines of communication and accountability. Regular meetings take place between elected members and senior leaders, in addition to formal scrutiny arrangements. The Health and Wellbeing Board is chaired by the Leader of the council who promotes an appropriate focus on children's issues. Investment from the Clinical Commissioning Group (CCG) has funded the health representative in the MASH.

98. The local authority understands its communities well, holding detailed information on the population of Wiltshire at a very local level. The nature of the military community in Wiltshire and the future planned changes in deployment are well understood. The DCS is a member of the Wiltshire's Military Integration Partnership which provides a forum to 'identify and respond to the military footprint' in Wiltshire.

99. The local authority is proactive in engaging with external sources of challenge and review. They have undergone a peer challenge on neglect and a Local Government Association diagnostic for services for children in care. Recommendations from these reviews have been incorporated into the relevant service area improvement plan. A strategy in relation to neglect is not yet in place and a number of strategic plans are very recent and have not yet demonstrated impact on outcomes for children and young people.

100. Suitable arrangements are in place to commission services for children and young people. Health and social care priorities are aligned, with an emphasis on

early intervention which will inform the redesign of community health services for children and young people. Consultation with children, young people and families underpin arrangements to commission services. One notable success has been the Special Educational Needs and Disabilities (SEND) service, which was designed with the active participation of the Wiltshire Parent Carer Council. Commissioned services have not, however, been sufficiently responsive to children's needs in relation to providing a choice of local foster homes for children and young people in care.

101. The DCS and senior management team are visible and prominent in arrangements to review, monitor and improve practice. The DCS chairs the improvement board, which the authority chose to continue following the end of formal intervention. In addition, all escalations from the child protection and reviewing team are reviewed by the DCS. Team performance review meetings have been an effective vehicle for senior managers to understand some of the issues that are impacting on performance in individual teams. This includes 'soft' cultural issues as well as staffing, data, audit, case escalation from child protection chairs and performance indicators. The trajectory for improvement is good, with demonstrable improvement in the quality of practice and outcomes for children and young people already achieved in some teams where there has been a legacy of poor practice.

102. While some performance monitoring measures are in place, the local authority does not consistently make systematic and effective use of all resources available to it to monitor and improve practice and outcomes for children and young people. Data to interrogate and improve performance are not sufficiently sophisticated across all areas of the service. For example, analysis and learning from complaints is limited and there is no formal system for the collation of comments or compliments that could inform practice development and improvement. Similarly, managerial scrutiny of practice has not sufficiently addressed shortfalls in relation to children in care where permanence is not secured in a timely fashion or where care proceedings have not been instigated promptly. The virtual school does not analyse data sufficiently to identify trends such as the progress of children educated outside the authority. The local authority is aware that the manual systems used to track performance in the adoption team are complicated and time consuming and is taking steps to address this.

103. The quality assurance framework has effectively evolved to focus on the quality of practice as well as compliance and now incorporates feedback from children and families. The local authority is confident in the judgements now made by managers when auditing case work. The reliability of these judgements is supported by their congruity with the judgements of inspectors during this inspection. Learning from auditing activity has led to the revision of policies and procedures in relation to supervision and visiting timescales. The local authority can also demonstrate improvements in the quality of practice. For example, 38% of cases in the safeguarding and assessment teams audited by the local authority in November 2014 were found to be inadequate. During the

inspection in July 2015, inspectors only identified three inadequate cases with no children at risk as a result of weaknesses. Additionally, cases judged to be good by the local authority improved from 12% in November 2014 to 45% in June 2015.

104. Elected members understand their role as corporate parents and can describe their direct involvement with young people. However, strategic corporate parenting arrangements are not yet sufficiently developed, have lacked direction and clear business plans and as a result have not had sufficient impact on improving services and outcomes for children and young people cared for by the local authority. Action is being taken to address this.

105. The local authority consults with children, young people and families, the views of whom have contributed to the shape of services. Children's wishes to reduce the number of changes of social worker they experience have led to the current model of service provision. 'You Said, We Did' demonstrates meaningful engagement with the Children in Care Council, and result in positive changes, based on young people's views, result. Examples include young people contributing to training for foster carers, induction training, changes to foster carer review forms, the redevelopment of early help assessments to improve the child's voice and continued commissioning of youth groups.

106. The local authority has made changes to the structure of services which have improved the consistency and quality of practice. The establishment of the MASH has been effective in providing a single point of access and prompt and appropriate responses when children are referred to social care. The early help service has been re-configured but is not yet sufficiently developed, though the partners are reportedly welcoming the recently revised strategy.

107. The local authority has rightly focused on the need to develop a stable, skilled and sufficient workforce. Cross-party political commitment has led to considerable investment in developing the service despite the current financial constraints on the council. Such investment has increased the number of social worker posts by 27, increasing capacity and supporting the aspiration of the authority's promise to reduce social workers' caseloads to 18.

108. A targeted recruitment strategy has made extensive use of social media, features in the professional press and senior leaders' appearances in the media and at recruitment events. This has led to the local authority receiving a significant increase in applications. In phase two of the current campaign, October 2014 to March 2015, 425 applications were received, compared with 105 applications in response to a traditional campaign in the previous year. Of these, 75 applicants have been offered and accepted posts. Despite this, 38 vacancies remain, 17 of which are in the safeguarding and assessment teams. Six of these vacancies are in just one of these teams which, as a result, has a disproportionate number of agency staff within it. This arrangement has, however, been closely monitored to ensure agency workers are of high quality and experienced.

109. New starters are now benefiting from maximum caseloads of 18 children and most established social workers described reducing caseloads to inspectors. This is allowing them to spend more time with children and families. However, some social workers, including some in their assessed year of practice, continue to have caseloads that are too high.

110. Where social work teams have continued to experience high staff turnover, senior managers have given thoughtful attention to stabilising and strengthening them. Improved managerial oversight is in place to ensure that thresholds are applied correctly and that risks are managed until stability and consistently good practice are achieved.

111. Arrangements to respond to child sexual exploitation in Wiltshire are not yet fully developed although young people now receive a timely and effective response to their need for protection from sexual exploitation. The local authority has been proactive in promoting awareness with elected members, communities and partners but its strategic and operational approaches are insufficiently robust. The local authority acknowledges that the commissioned service for completing missing return interviews for children and young people who go missing has not been sufficiently rigorous. New arrangements to complete these interviews have been recently made and early signs of improvement are evident.

112. Effective arrangements are in place for liaison between the local authority, the Family District Judge and Cafcass. This has had a significant positive impact on the timeliness of proceedings which currently stand at 24 weeks.

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.

A Local Safeguarding Children Board (LSCB) requires improvement if it does not yet demonstrate the characteristics of good.

Executive summary

The Wiltshire Safeguarding Children Board (WSCB) has made slow progress from a low base, but has benefited from increased partner engagement. Governance and accountability arrangements are in place. However, capacity issues, restructuring and changes of subgroup chairs and membership of the board and subgroups have reduced the timeliness of developments. Effective monitoring has not yet been sufficiently established across the partnership. As a result the board does not yet have an evaluative oversight of the performance and impact of all services on outcomes for children.

Safeguarding practice is scrutinised by the board through the use of single and multi-agency audits, section 11 audits and the annual schools safeguarding audit. These have led to action plans, which the board and partners are monitoring to ensure these lead to improved front-line practice. The WSCB is still developing its multi-agency performance dataset, aligned to the Wiltshire Performance Web and board priorities. Although the WSCB does make judgements about front-line practice across agencies, the absence of a developed framework impacts on the board's ability to fully identify, challenge or escalate concerns about practice in frontline services delivered by all partners.

The WSCB has played a key role in engaging partners in the safeguarding agenda and coordinating their response to missing children and child sexual exploitation. The board's monitoring of the effectiveness of partnership practice in this area is underdeveloped.

The WSCB has disseminated learning from serious case reviews and other serious incidents across the partnership. Most agencies have responded positively and there have been discernible improvements in practice as a result. However, learning from these reviews within children's social care is not as well evidenced.

Peer reviews across the partnership have highlighted areas for improvement, including the need for a neglect strategy, work on an operational multi-agency child sexual exploitation group and a greater focus on children in care. These areas are yet to be developed and reflected in the board's business plan.

Recommendations

113. Revise and refresh the board's dataset to ensure a wider focus on performance with improved partner agencies data.

114. Ensure that the development of child sexual exploitation and missing procedures creates a joined-up partnership approach, scrutinising the timeliness and quality of missing return interviews to analyse intelligence and develop a better understanding of missing behaviour and wider child sexual exploitation profiling.

115. Ensure that a neglect strategy is developed and, once finalised, integrated into clear multi-agency procedures that are widely disseminated and implemented across the partnership.

116. Create a formal means of recording challenges made to partners and their responses, to review progress, evaluate impact on practice, analyse themes and share wider learning to all partners.

Inspection findings – the Local Safeguarding Children Board

117. Governance arrangements between the WSCB and the local authority are effective and help the board carry out its statutory responsibilities. The Executive Directors, in their rotating chief executive role, hold the chair of the WSCB to account and ensure that safeguarding is a key priority across the partnership in Wiltshire. There are effective links between the WSCB, the Health and Wellbeing Board (HWB) and the Lead Member and this has further strengthened the delivery of the board's statutory responsibilities.

118. A revision of the board's structure has been initiated by the chair and the board has undergone significant structural redesign, appropriately reducing from 17 to nine subgroups. This has streamlined key activity on priorities identified by the board and enabled more decisive and robust coordination of services and evaluation of safeguarding performance across Wiltshire. The roles and responsibilities of many partner agencies are common to both Wiltshire and Swindon, with the child sexual exploitation strategic group and child death overview panel (CDOP) subgroup working effectively under pan-Wiltshire arrangements.

119. The board has representatives from all key partners, including the voluntary sector, a lay member and young people. The majority of board members are of sufficient seniority to have influence and effect change in their own organisations and across the partnership. The Chair has succeeded through challenge in improving consistency of representation at board meetings of most partner agencies and sectors including headteachers and the military. All WSCB partners make suitable financial and resource contributions.

120. The WSCB has ensured that multi-agency policies and procedures are fit for purpose, are reviewed effectively and reflect changes in practice. The board has challenged partners on issues such as performance information data, financial contributions and dissemination of learning across the partnership. However, this level of challenge and sustained focus has not always been sufficiently rigorous or well driven. For example, the board does not keep a formal record of challenges and responses and as a result it is difficult for it to effectively review progress, analyse themes or share wider learning to all partners to evidence positive changes in practice.

121. The board promotes the voice of children and receives regular feedback within reports. Young people from the Children in Care Council regularly attend and pose questions and challenge partners, ensuring the wishes and feelings of young people remain constantly considered by the board.

122. The use of performance information by the WSCB to evaluate performance across the partnership is underdeveloped. The multi-agency dataset is not yet comprehensive and the board is therefore unable to scrutinise performance information effectively. While the board is in the process of addressing this area for development, this currently inhibits the WSCB's ability to assure itself of all safeguarding performance across the partnership. For example, the missing and child sexual exploitation subgroup are not using all relevant data. This weakens the board's ability to analyse data and assure itself that partners' approaches to children at risk of child sexual exploitation are meeting need.

123. There have been improvements in the board's understanding of the effectiveness of local practice to safeguard children through training and development sessions on performance information. However, until the dataset is a fully functioning tool and scrutinised robustly, this learning is limited and as yet is not sufficiently influencing practice and outcomes for children and young people in Wiltshire.

124. The WSCB, supported by the quality assurance and performance subgroup, have developed a comprehensive audit framework and commissioned a range of multi-agency and single-agency audits to review practice. These audits are scrutinised at the quality assurance and performance subgroup and regularly presented to the board. Audit findings and recommendations are identified and implemented by partners, and learning from audit activity is widely disseminated across the partnership. Partners were able to demonstrate how audits have contributed to improved safeguarding in Wiltshire, for example the implementation of changes to the policy on non-mobile babies following a partnership review.

125. Audit activity is well embedded and partners understand and are well engaged in the audit cycle. Section 11 audits have been scrutinised and feedback about the quality of audits, is used to shape partners' action plans. The board has made further developments in section 11 audits. For example, it has added specific child sexual exploitation questions for 2014–15 and will add specific

questions on female genital mutilation and radicalisation in the 2015–16 audits. The annual schools safeguarding return has shown improvements in practice through the work of the board, for example, the increase in appropriate referrals on the management of allegations against staff and volunteers following well-attended multi-agency training.

126. While the WSCB has developed a learning and improvement framework, capacity issues have adversely affected the board's ability to effectively review and update the framework. The board has not yet undertaken a multi-agency training needs analysis to inform the future training plan and ensure a closer alignment between needs and delivery. As a result the board cannot currently assure itself that training needs across the partnership are effectively met. The board has, however, ensured that there are improvements in multi-agency training attendance and evaluation and these are monitored effectively through a regular training report. The WSCB has recently implemented a training programme on responding to individuals who are vulnerable to messages of violent extremism under the Prevent strategy, with 'train the trainer' workshops being rolled out to partners. It is too early to see the impact of this on practice.

127. Serious case reviews are initiated appropriately and in accordance with statutory guidance. Learning from serious case reviews is a key priority for the board and lessons are disseminated effectively across the partnership. While representatives from partner agencies are able to demonstrate how this learning has improved their practice, learning within the children's social care workforce is limited. Training and implementation of Social Care Institute for Excellence (SCIE) methodology for serious case reviews and partnership reviews have received positive feedback from partners. The board has integrated learning from several peer reviews, and key messages from these have been used to target key areas for development. For example, one peer review has led to the current development of the neglect strategy and this was accompanied by the delivery of high quality multi-agency training on neglect.

128. The WSCB has benefited from strengthened participation and input from the Clinical Commissioning Group (CCG) and Health Trusts. This has resulted in improved focus and understanding of safeguarding responsibilities across the health partnership. For example, the commitment to safeguarding is increasing general practitioners' participation in safeguarding training and improving the quality of single agency audits to evaluate practice. The CCG actively monitors performance for compliance and quality, and this information is now contributing to the new WSCB performance dataset.

129. The child death overview panel (CDOP) has made improvements to CDOP processes and practice across the partnership, for example updated rapid response procedures are in place. The stability of the partners and chair on the subgroup has led to sustained development, with regular comprehensive analysis of cases to understand incidents of child death, themes and patterns. Joint campaigns with police, public health and other partners on specific issues

such as learning for health visitors on environmental health issues has further strengthened responses to child death incidents.

130. WSCB is part of the wider South West consortium, which jointly produces safeguarding procedures. While all WSCB policies and procedures are in place, and reviewed at regular intervals to ensure they are fit for purpose, some policies have not been updated to make them compliant with Working Together to Safeguard Children 2015. For example, the information sharing policy continues to refer to Working Together to Safeguard Children 2013. This area for development has been identified by the board, although work has yet to be initiated.

131. The WSCB has been slow to respond to the challenges associated with child sexual exploitation. Partners are now actively engaged in this agenda and are routinely contributing to service improvements and awareness-raising. For example, 25 of the 29 secondary schools in Wiltshire have run a child sexual exploitation awareness raising event. The recent targeted focus from the board has contributed to strengthened arrangements to identify and support children at risk of sexual exploitation. For example, Wiltshire police have led on the development of a pan-Wiltshire initiative to tackle child sexual exploitation (Project Gemstone) and this has resulted in the development of a newly established multi-agency child sexual exploitation team (Emerald). Information gathered from this activity has further contributed to the board's ability to analyse intelligence and themes and use key messages from local intelligence to target resources.

132. The board has actively challenged the fact that information gathered from missing return interviews is not used to develop a better understanding of missing behaviour and wider child sexual exploitation profiling. This challenge has now resulted in an improving awareness on the part of practitioners to offer return interviews. Additionally, the police have commenced awareness-raising activities, including visits to taxi drivers and fast food outlets. However this activity is not sufficiently established to ensure local businesses are aware of risk, intelligence is gathered and disruption activity undertaken. A range of awareness raising activity, information and training on female genital mutilation has recently been widely disseminated with partners including health and schools, although it is too early to see how well this learning is used.

133. While the 2013–14 WSCB annual report sets out clear priorities, it does not provide a rigorous assessment of local performance and effectiveness of services. The report is not sufficiently evaluative and does not reflect a comprehensive overview of the quality and impact of services delivered across Wiltshire to children and young people. There is a limited analysis of some issues, for example children in care and private fostering. This has been identified by the board and the forthcoming annual report, while not yet published, and seen by inspectors only as a draft, does contain a critical analysis of achievements and sets out a clear rationale for future priorities.

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.

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