West Sussex County 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: 26 October – 19 November 2015

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Children's services in West Sussex County Council require improvement to be good		
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 Inspections Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

Executive summary

At the time of this inspection, services for children provided and delivered by the council, including those in need of help and protection and those looked after, require improvement. However, while services are not yet good in West Sussex, inspectors saw evidence of some positive work delivered for children that was improving outcomes for them. Inspectors also saw strong senior leadership supporting a comprehensive improvement plan. There has been a whole systems redesign of services, with some significant staffing changes at strategic and operational level, but the local authority knows itself well and is aware there is still more to do. Elected members are able to confidently articulate the range of developments implemented across the service and how they have supported them, including through the provision of significant financial investment. The plans in place are driving progress and positive impact for children right across the service.

Many of the recommendations from previous inspections have been implemented, with positive results. A comprehensive multi-agency early help offer is now in place, with strategic oversight provided by the Start of Life Partnership Board.

However, some recommendations from previous inspections have not been followed through. The timeliness of initial child protection conferences, while having improved, continues to be a challenge. At the time of the inspection, a small number of care leavers live in bed and breakfast accommodation, which is inappropriate. Too many children have experienced changes of social worker, which affects the stability of relationships between workers and young people. In some cases, this was a hindrance to plans progressing. However, this situation is improving: the workforce continues to stabilise as the service redesign embeds further.

A cornerstone of the service redesign has been a significant increase in management capacity. Many of the newly appointed managers are undertaking their first management roles. Some good quality management oversight and supervision of social workers was seen during the inspection. However, not all cases demonstrated sufficiently rigorous management drive to make sure that plans for children are progressed within their timescales.

The redesign has also resulted in an increase in social work capacity and administrative support for social workers. Recruitment to vacant posts is progressing positively. Social workers feel well supported by their immediate managers and by senior managers. There is good support for newly qualified social workers from the 'social work academy'.

A comprehensive quality assurance framework is beginning to give the local authority a rich picture of the standard of practice with children, but there is still more to do to ensure that the quality assurance framework is contributing to good practice consistently across the service. Findings from learning audits result in clear action plans. The local authority plans to repeat the audits as part of the established learning audit cycle to assess whether change has been achieved and sustained.

The implementation of plans to improve services is a strength because it is undertaken in partnership with elected members, workers throughout the organisation, partner agencies, children and young people and their parents or carers. This has ensured wide-ranging support and ownership for the redesign of services. A clearly defined approach to casework underpins the implementation of the redesign well. During the inspection, there was strong evidence that the changes are having a positive impact on the quality of work with children and families.

There is a strong early help offer that is valued by families and partners, who can see evidence of effective support to children in need. Decisive action is undertaken for those children identified as being at risk, but some processes need to be strengthened to ensure compliance with the Department for Education's 'Working Together 2015'. For example, strategy discussions should include all relevant partners to ensure that all available information is shared. This enables professionals to make informed decisions about safeguarding practice.

Work on child sexual exploitation, missing children, female genital mutilation, radicalisation and child trafficking is progressing on a pan-Sussex basis. Good examples of work with individual children were seen in each of these areas. However, local arrangements are not as strong. The local authority lacks a detailed picture of the prevalence of these issues to help drive its strategic response locally. Return interviews for children who have been missing from home or care are a particular weakness. These are carried out in too few cases and when they are carried out, they are not always of good quality. This means that the local authority lacks a comprehensive picture of the reasons for children going missing, limiting its ability to respond in a positive way to improve safety for children and young people.

The quality of adoption work is improving but more needs to be done to ensure that permanency planning is timely and robust.

Services for children looked after, including those with a permanence plan and care leavers, need further development to ensure that they are good. Educational outcomes for children looked after are improving, but this does not extend well enough to care leavers. Too many care leavers are not engaged in employment, education or training when they are 19 years or older.

There remain some gaps in health provision for children looked after and care leavers. Currently, unreliable health data mean that the local authority cannot be confident that all children receive timely health assessments. In addition, strengths and difficulties questionnaires are not used to inform the understanding of children and young people's emotional and mental health needs. A plan is in place to address this, but has yet to show impact.

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The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates seven children's homes. All were judged to be good or outstanding in their most recent Ofsted inspection.
- The previous inspection of the local authority's arrangements for the protection of children was in February 2013. The local authority was judged to be adequate.
- The previous inspection of the local authority's services for children looked after was in November 2010, as part of the inspection of Safeguarding and Looked After Children (SLAC) inspection. Services for children looked after were judged to be adequate at this inspection.

Local leadership

- The Executive Director of Care, Wellbeing and Education (statutory director of children's services – DCS) has been in post since February 2015.
- The DCS is also responsible for adult services, education and skills, public health and social care commissioning
- The chair of the Local Safeguarding Children Board (LSCB) has been in post since January 2012.
- The local authority has adopted the Signs of Safety methodology to inform and underpin the service redesign. In this report, this is referred to as the local authority adopting a clearly defined approach to casework.

Children living in this area

- Approximately 168,835 children and young people under the age of 18 years live in West Sussex. This is 20.4% of the total population in the area.
- Approximately 13% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 10.5% (the national average is 15.6%)
  - in secondary schools is 8.7% (the national average is 13.9%)
- Children and young people from minority ethnic groups account for 9.9% of all children living in the area, compared with 21.5% in the country as a whole.

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

- The largest minority ethnic groups of children and young people in the area are Asian/Asian British (7,420 0–17-year-olds in 2011; largest sub groups – Other Asian 2,125 and Asian Indian 2,060) and Mixed/multiple ethnic group (6,290 0–17-year-olds in 2011; largest sub groups – White and Asian 2,275).
- The proportion of children and young people with English as an additional language:
  - in primary schools is 10.4% (the national average is 19.4%).
  - in secondary schools is 8.1% (the national average is 15.0%).
- Bilingual pupils make up 9.8% of the total school population in West Sussex.
- West Sussex schools have recorded entries against over 150 different language categories (including British and Other Sign Languages). Gypsy, Roma and Traveller pupils make up less than 1% of the school population.

Child protection in this area

- At 30 September 2015, 2,746 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 2,566 at 30 September 2014.
- At 30 September 2015, 474 children and young people were the subject of a child protection plan. This is a reduction from 502 at 31 March 2015.
- At 30 September 2015, 13 children lived in a privately arranged fostering placement. This is an increase from 11 at 31 March 2015.
- Since the last inspection, three serious incident notifications have been submitted to Ofsted and one serious case review has been completed.

Children looked after in this area

- At 30 September 2015, 639 children are being looked after by the local authority (a rate of 36 per 10,000 children). This is a decrease from 640 (38 per 10,000 children) at 31 March 2015. Of this number:
  - 107 (or 17%) live outside the local authority area
  - 48 live in residential children's homes, of whom 50% live out of the authority area
  - five live in residential special schools, three of whom live out of the authority area
  - 439 live with foster families, of whom 12.3% live out of the authority area
  - eight live with parents, of whom none lives out of the authority area
  - 46 children are unaccompanied asylum-seeking children.

- In the last 12 months:
  - there have been 35 adoptions
  - 35 children became subject of special guardianship orders
  - 361 children ceased to be looked after, of whom 10% subsequently returned to be looked after
  - 46 children and young people ceased to be looked after and moved on to independent living
  - 24 children and young people ceased to be looked after and are now living in houses of multiple occupation.

Recommendations

1. Strengthen the quality of child protection decision-making so that thresholds are appropriately and consistently applied. This particularly includes decisions to convene initial child protection conferences and decisions to end child protection plans at the first review.

2. Ensure that managers carefully oversee casework assessments, plans and reviews so that these demonstrate timely and purposeful work with children in accordance with their timescales and so that children are visited in line with statutory requirements.

3. Ensure that key agencies attend or provide information so that all strategy meetings are compliant with statutory guidance.

4. Strengthen the quality of planning for children in need of protection, children looked after and care leavers so that plans are clear about intended outcomes and timescales and clear about who is responsible for actions and have agreed contingency plans.

5. Improve the overall quality of reviews for children looked after and care leavers, including their timeliness, level of challenge and robustness of decision-making, so that these are effective in overseeing and driving forward plans.

6. Urgently address the high number of care leavers who are not in employment, education or training to ensure that more young people have access to opportunities that will support them into independence.

7. Improve the range of accommodation options on offer for care leavers so that they can move from supported accommodation to independent living accommodation when they are ready. Discontinue the use of bed and breakfast accommodation for care leavers other than in exceptional emergency circumstances.

8. Ensure that return interviews are consistently undertaken for children who go missing, that they are timely and of good quality, and that the information

obtained from these interviews is used to inform planning and risk management, for individuals and strategically.

9. The local authority should request that the Clinical Commissioning Groups ensure that delays in health assessments, the lack of completed strengths and difficulties questionnaires and timely access to treatment in Child and Adolescent Mental Health Services (CAMHS) for children looked after are addressed quickly and effectively. Concerns should be escalated to the Health and Wellbeing Board.

10. Ensure that all children looked after and care leavers are helped to understand why they are in care and what their entitlements are. In particular, review the capacity of the independent visitor and advocacy services so that those children who could benefit from them can do so.

11. Where plans for children to be adopted are changed, ensure that alternative plans are pursued in a timely manner so that permanence is secured for these children without unnecessary delay.

12. Improve practice in relation to adoption support so that: responses to requests for adoption support are timely; adoption support assessments are comprehensive and completed in a timely way; adoption support plans have clear outcomes, measures and timescales against which to assess progress; and plans are reviewed regularly.

13. Ensure that there are robust systems in place to enable the designated officer to respond and track the outcomes of investigations into allegations against people working with children within suitable timescales.

Summary for children and young people

- The Director of Children's Services and other senior managers have recently made some big changes to the way that help is given to children and their families.
- The Director of Children's Services and other senior managers have recently made some big changes to the way that help is given to children and their families.
- Another thing that is better is that there are now more managers to help social workers do their jobs well. Managers also make sure that plans for children are making things better for the children.
- Plans for most children are good enough to make sure that the help keeps them safe and that things get better for children. For some children, the help stops too soon, before things have really had a chance to improve.
- Some children have had too many changes of social worker. This means that some children have not been able to get to know their social worker properly. The local authority knows about this and has taken steps to improve this. Changes of social worker are happening less often now.
- The plans for children in care are not always reviewed as well as they should be. Sometimes, the review does not look carefully enough at everything that is important for children. This can mean that things don't happen that need to, or that they don't happen quickly enough.
- Children in care are given help but for some children this could be better to make sure they do as well as they can in school.
- Young people who have left care get on very well with their personal advisers. Sometimes, there are not enough of the right places for care leavers to live, and some care leavers spend too long living in bed and breakfast places.
- When children are adopted, help to make sure this goes well needs to be given sooner and plans should be clearer.
- Sometimes, no-one visits children who go missing from home or from care when they come back. This can mean no-one finds out why the child went missing so they can help stop it happening again

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

Summary

The local authority has made progress against most of the recommendations of the child protection inspection in 2013. The targeted early help offer in the local authority has developed significantly, with more children and families receiving earlier, outcome-focused support that is becoming increasingly effective. The Early Help Resource Centre screens and processes referrals effectively so that services are targeted appropriately to support families.

The Children's Access Point responds effectively to new referrals, although there is delay in progressing some referrals. The application of thresholds is appropriate at the referral stage. For some children in need, there are long gaps between visits, and plans are not always sufficiently clear or reviewed regularly enough.

Decisive action is taken when children are identified as being at risk of significant harm. This results in timely strategy discussions and child protection enquiries. Information-sharing is appropriate to inform decisions regarding next steps. However, too many strategy discussions do not include all key partners, particularly from health.

Social workers see most children regularly. Assessment practice is improving, supported by the effective use of a clearly defined approach to casework. Assessments are analytical and lead to useful recommendations, reflecting the voice of the child and the diverse needs of each child in the family.

For some children, initial child protection conference decision-making is inconsistent. Police partners have not attended some conferences. Child protection plans are not always robust. Some plans end too early, before change has been achieved and progress sustained. Danger statements in child protection planning are strong. They are clear in explaining what exactly the risk is and how this can be reduced. However, managers do not consistently drive forward children's plans, so drift occurs and children do not get the help they need within a timescale appropriate to their needs.

Too few young people who go missing receive a return home interview. When return interviews are carried out, this is not always within the expected timescales and they are not always of good quality.

The response to individual children and young people identified as being at risk of sexual exploitation, female genital mutilation or radicalisation is a strength. The Designated Officer responds effectively to allegations against those working with children. However, arrangements for tracking progress with, or outcomes of, investigations need to be improved.

Inspection findings

14. The development and implementation of the early help offer gained pace in the six months prior to the inspection, with key strategic and operational developments recently in place. There is further work required to fully implement the strategy and embed improvements across the service. From a low baseline, there has been a significant increase in the number of early help plans initiated during the past year. Performance management reporting indicates that 78% of families have shown a positive reduction in need. The local authority reports that the Think Family programme (the local name for the national 'troubled families' programme) has successfully turned round 1,165 families in phase one of the Troubled Families scheme, and is integrated within the overall early help offer.

15. The multi-agency Early Help Resource Centre effectively screens and processes referrals for early help, ensuring that services are targeted appropriately. Positive progress was evident in the majority of early help plans and reviews, although there were delays in long-term allocation for the Think Family service at the time of inspection. When needs escalate, cases are stepped up appropriately, with effective joint work between children's social care and early help services. The quality of service coordination at the point of step-down is variable, with good practice not consistently evident. However, the number of families receiving targeted early help offers has doubled over the last year and the large majority of plans seen were well crafted. This is a significant improvement on the arrangements seen at the previous inspection.

16. Qualified social workers in the Children's Access Point screen all contacts and offer consultation to partner agencies. Decision-making is proportionate to referral concerns and consent from parents is sought appropriately. Consideration is given to providing support at the earliest stage to prevent needs escalating. Threshold guidance is routinely used to inform decisions, all of which are overseen and signed off by qualified managers.

17. Delays in progressing contacts were identified in a small minority of contacts reviewed by inspectors. Although these delays were not identified in respect of any children at risk of harm, they mean that some families wait too long to be told about the outcome of decisions. The local authority acknowledges that this has been an area of challenge and has implemented systems for managing risk in this respect. This includes end-of-day triaging and paying overtime for administration workers to input contact information onto the system.

18. Capacity is also impacted on by the police practice of referring all police incidents where a child is linked to a household, no matter how minor. This practice has been subject to discussions between the local authority, police and the Local Safeguarding Children's Board (LSCB). As a result, a new approach has recently been implemented and all police notifications are now considered at a multi-agency morning triage meeting. It is too early for the impact of this change to be seen.

19. Between 1 April and 30 September 2015, 71% of children and families assessments were completed within expected timescales. There is evidence of strengthening practice in assessments, but decision-making in nearly a third of assessments takes too long for children. A minority of cases with overdue assessments had started intervention programmes, indicating that managers should have ensured that the assessments were completed earlier and children in need plans devised sooner. A number of assessments seen by inspectors were of good quality and included detailed chronologies and background histories. Need, risk and protective factors were well considered, resulting in well thought out safety plans. Assessments reflect the voice of the child and consider the diverse needs of each individual child within the family. This consistent approach produces confident analysis and appropriate recommendations.

20. Practice in respect of pre-birth assessment and planning is less consistent. Delays in assessments were identified in a majority of cases seen and opportunities to complete thorough assessments were compromised as a result. The absence of a template for recording pre-birth assessments creates inconsistencies in practice. Inspectors also saw some examples of good assessments, with robust analysis leading to clear multi-agency plans.

21. A high proportion (75%) of assessments lead to no further action. Despite audit and analysis work, the local authority has not been able to fully understand the reasons for this. It has found thresholds for decisions to progress to assessment to be appropriate. This is in line with inspectors' findings in the cases sampled.

22. There is strong emerging evidence of the effective use of a clearly defined approach to casework. This is shown in the clear and well-formulated initial danger statements written by the Children's Access Point Team and throughout subsequent help and protection intervention. Mapping of strengths and worries is undertaken and danger statements are revised to reflect families' changing circumstances. This means that assessment is a dynamic process. This approach makes it clear for families what needs to change.

23. Child in need plans are in place, but overall child in need planning is not sufficiently well developed. Some plans are of good quality, but others lack specificity, timescales and contingencies and are not reviewed sufficiently regularly. Children in need are visited by social workers, but in several cases, this was not sufficiently regular to drive planning. In these cases, there was also insufficient managerial oversight to address this shortfall. The local authority has recently taken steps to address this through increasing managerial capacity and developing advanced practitioner posts, with a focus on children in need. These practitioners will take a lead on driving child in need planning for those children's cases that have stepped down from child protection plans, as well as supporting social workers in chairing complex child in need meetings. However, these posts are only recently established and are yet to show impact (recommendation 4).

24. Children are seen regularly by social workers and their voices are evident in case recording. Social workers involve children and young people in planning through the use of direct work. Inspectors saw examples of effective involvement of young people in their own safety planning, contributing to more effective safeguarding arrangements for children and young people.

25. When children are identified as being at risk of harm the response is robust. The Emergency Duty Team's response to concerns arising out of hours is timely and proportionate. Most child protection enquiries are comprehensive, leading to appropriate protective action. Agency information is included, but too often strategy discussions only include police and social care. In particular, health professionals have not always been invited to strategy discussions, which has impacted adversely on shared decision-making (recommendation 3).

26. This issue has been the subject of challenge across the partnership, with work undertaken by children's social care to increase compliance. A recent audit by the local authority has identified an improving picture, although the impact of this work was not apparent in the cases sampled by inspectors during the inspection. The local authority anticipates that the introduction of a multi-agency service hub in March 2016 will strengthen agency collaboration and communication in this respect.

27. Progress in convening initial child protection conferences within statutory timescales has improved from a low base of 59% in 2014–15 to 72.3% for the period from 1 April to 30 September 2015. However, during September, a reduction in the timeliness of initial conferences occurred as child protection advisers had insufficient capacity to chair conferences due to high sickness levels and annual leave. The local authority added capacity to child protection arrangements earlier in 2015, but should ensure that in future no initial conferences are postponed due to a lack of availability of chairs.

28. Child protection conferences do not consistently include all the necessary agencies. The police were absent from two initial child protection conferences sampled where their attendance would have been beneficial to decision-making. The local authority had addressed this issue with the police just prior to the inspection, resulting in an agreement for increased police capacity to enable attendance. Child protection advisers report seeing very recent improvements in this respect.

29. Decision-making at initial child protection conferences is variable and this is a weakness. Conferences follow the clearly defined approach to casework in considering risk, but are not always effective in reaching appropriate threshold decisions. In one case seen, a decision had been made to progress to a child protection conference prematurely when further assessment was needed. The local authority has completed a 'deep dive' audit to assist their understanding of the reasons for high numbers of children being prematurely removed from a child protection plan within three months. This audit found that a number of cases had progressed to child protection conference when the threshold

significant harm had not been met. Scrutiny of decisions to proceed to an initial child protection conference on conclusion of child protection investigations is insufficiently robust (recommendation 1).

30. Young people are supported to attend child protection conferences. Child protection advisers seek feedback from parents and young people who attend child protection conferences to inform learning and service development. Feedback from parents and young people over the last six months indicates that they understand the purpose of conferences and feel well supported to have their views heard.

31. Child protection plans developed at conferences include clear danger statements. Most plans set out the actions that are needed. However, timescales and contingencies are not always clear. When plans are reviewed at subsequent child protection conferences, there is too much focus on information-sharing rather than on reviewing progress against the plan (recommendation 4).

32. In most cases seen by inspectors where child protection plans had ended at the first review, the decision to end the plan had been taken before the necessary changes were achieved and before it was clear that the risk of harm or actual harm had reduced. There was a reliance on self-reporting from parents and over-optimism from conference members, including the conference chair. The potential impact of this is that unresolved risk will escalate again. The local authority had identified this issue prior to the inspection and work had commenced with the child protection advisers to strengthen decision-making. This includes providing additional scrutiny of all plans that end at the first review. Nearly a quarter (24%) of children who become subject to a child protection plan have previously been subject to a plan, suggesting that premature removal from plans may be a significant factor in this trend (recommendation 1).

33. As at 30 September 2015, there were 477 children subject to child protection plans. Six per cent of these children were subject to a child protection plan due to concerns regarding physical abuse, 7% due to sexual abuse and 23% due to neglect. The remaining 64% of children were subject to plans due to concerns about emotional abuse. The local authority has reviewed practice in respect of the high incidence of children subject to a child protection plan under the category of emotional abuse. This work revealed that some child protection advisers have been using this category for all situations where domestic abuse was the presenting issue. Work has commenced to address this, but had not yet had an impact at the time of the inspection.

34. The development of the neglect strategy and action plan is strengthening the response to neglect across the service. The strategy relies heavily on the use of the clearly defined approach to casework, supported by a range of direct work tools. The use of these direct work tools was evident across a range of cases sampled during the inspection. These provide a good representation of the

child's voice and lived experience, helping to direct intervention more effectively. Chronologies are in place for most of the cases seen and are a useful tool to help identify concerns regarding neglect. However, the use of the graded care profile, introduced by the LSCB to support practitioners in assessing and responding to neglect, was less evident.

35. Domestic abuse is a cause for concern for 64% of the children subject to child protection plans. Families experiencing domestic abuse have access to a range of support services, with examples of reduction in risk seen by inspectors during case sampling. However, in other examples, cases were stepped down before the impact of this work was evident. West Sussex is participating in a national pilot for work with perpetrators of domestic abuse, which will start in January 2016. There is a robust multi-agency approach to domestic abuse, with strategic and operational links to children's services. Multi-agency risk assessment conferences (MARAC) across the county have effective multi-agency participation and maintain a clear focus on children as part of their work.

36. The local authority is aware of the prevalence of parental drug or alcohol misuse and the impact of parental mental ill health for children with child protection plans. Of the children subject to a child protection plan at the time of the inspection, 30% featured concerns regarding parental mental ill health and 49% concerns regarding parental drug and alcohol misuse. A range of services are available for those children and families experiencing difficulties due to substance misuse and mental ill health. Some examples were seen of families engaging positively with these services.

37. In most cases, management oversight was evident at key decision-making points throughout the child's journey, although it was not purposefully progressing plans and reviews in all cases. Assessment plans are set out at the start of intervention in the form of management notes, and provide clear direction. Supervision is evident on children's electronic records, but managers' reasons for decisions are not always recorded, nor is progress against the plan consistently considered. The impact of this practice is that plans are not always sufficiently driven, leading to drift and delay (recommendation 2).

38. Professionals in the partnership have good awareness of child sexual exploitation and take action to refer children to the Children's Access Point when risk is identified. Children identified as being at risk of sexual exploitation are the subject of a strategy discussion and considered at the multi-agency child sexual exploitation (MACSE) meeting. Where risks are not reduced, cases are escalated. In one case seen, this resulted in a young person being made subject to a child protection plan. This demonstrates a robust approach to the protection of children at risk of sexual exploitation. At the time of the inspection, 44 children were known to be at risk of sexual exploitation. Support plans are holistic and consider wider needs. Direct work is provided from a commissioned service. The coordinated support provided to these young people is reducing the risks of sexual exploitation effectively.

39. Arrangements are in place for responding to the needs of young people who go missing, but practice is not yet consistent. An independent provider has been commissioned to carry out return home interviews. Attempts are made to contact young people and offer a return home interview in response to notifications. However, at the time of the inspection, only 40% of notifications received since 1 April 2015 had resulted in a return interview. Of the interviews undertaken, only 70% were carried out within the required 72-hour period. At the time of the inspection, 14 children had been identified as missing on one or more occasion in recent weeks. The local authority is not sufficiently proactive in ensuring that all children who go missing receive a timely, effective safeguarding response and have only recently begun to address their concerns with the commissioned provider (recommendation 8).

40. Recording of missing incidents and return home interviews is not always evident on children's files. As a result, the local authority cannot be assured that effective plans are in place to drive intervention, respond to need and reduce risks. Examples were seen where timely return home interviews had been undertaken, and missing activity had been well recorded and analysed, resulting in effective risk assessment and risk reduction. However, return interviews do not always detail the reasons for the missing episode, the push and pull factors or the measures that need to be in place to reduce missing episodes (recommendation 8).

41. The incidence of children absent from primary schools decreased in 2013–14. The authorised absence rate fell by 1.2% and the persistent absence rate by 0.8%. This is an improvement in comparison to national averages. For secondary schools, the incidence of children absent in 2013–14 decreased. The authorised absence rate was down by 1% on the previous year to 4.1% and the persistent absence rate to 5.3%, to around national averages. The persistent absence rate for children in need decreased by 3.4% in 2013–14 to 12.3%. Data held by the local authority indicate that, in 2014–15, the overall absence rate increased marginally on the previous year to 4.5%, while the unauthorised absence remained the same at 0.68%.

42. There are 480 children electively home educated. The local authority takes a proactive approach to children educated at home and has visited and assessed the suitability of arrangements for 476 of these children.

43. The manager responsible for pupil entitlement has good oversight of the situation of children missing education and those children coming from outside the county. Appropriate thresholds are set that trigger a clear process for investigating why children and particularly vulnerable young people go absent from school. Where a child is missing from school for 10 days, there are clear intervention policies and good collaboration with schools. Head teachers are fully aware of the procedures. Managers implement effective policies that resolve exclusions. The number of children missing education cases at the time of the inspection was 211.

44. The youth homelessness prevention service includes specialist housing and youth workers. It supports 16- and 17-year-olds at risk of homelessness effectively. The workers are based in the 'FindItOut' centres for young people, located across the county. The service assesses the needs of young people with a focus on supporting them to remain in their families where possible. Mediation and advocacy are provided. Where young people cannot remain with their families, specialist temporary emergency accommodation is provided while waiting for an urgent joint housing assessment. The assessment includes explanation of rights and entitlements, including the option of becoming looked after. Between 1 April and 31 October 2015, 107 16- and 17-year-olds presented to the service, of whom four were accommodated under section 20 of the Children Act 1989. A number of young people presented who were over 18 years of age and a further cohort chose not to engage. Cases seen by inspectors demonstrated appropriate assessments and interventions for young people who accepted the services offered.

45. Arrangements to respond to the needs of privately fostered children have improved since the last inspection. All those referred to the service in 2014–15 were visited within required timescales and their needs assessed. There were 13 children in a private fostering arrangement at the point of the inspection. There is appropriate intervention to support this group of children and young people, including child-centred direct work. However, when additional needs are identified that require social work intervention from the family support and protection teams, the response is variable, with too much resistance to accepting case responsibility.

46. The designated officer responds effectively to allegations against those working with children at the point these are made. However, timescales and outcomes of investigations are not recorded and tracked effectively. As a result, the local authority cannot be assured that investigations are being robustly progressed within suitable timescales. Additional administrative support has been provided to improve tracking, but progress is too slow (recommendation 13).

47. The multi-agency partnership has taken a proactive approach to identifying and responding to concerns regarding female genital mutilation. The pan-Sussex Harmful Practice Management Group has led on developing a strategy and policies, as well as undertaking risk mapping. Awareness-raising has taken place and a communications strategy is due to be launched in February 2016. There is a robust and proactive multi-agency approach to identifying female genital mutilation and trafficking concerns, supported by specialist social work posts. Arrangements for identification are effective, with two cases being identified in recent months.

48. The local authority has responded proactively to the risk of radicalisation. A prevent strategy has been developed and a lead officer within the local authority oversees and chairs the Channel panel, which is well attended by partner agencies. The panel responds to individual concerns regarding the risk of radicalisation for individual children and young people, developing plans to

respond to identified risks. Examples were seen where these plans had successfully reduced risk to young people. The local authority meets its responsibility to raise awareness of the risk of radicalisation, having trained over 1,500 professionals across the council since this work began in 2011.

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

Summary

Decisions where children should become looked after are appropriate, and plans for children to return home are generally effective. The quality of work prior to and during care proceedings is good. The average length of care proceedings has significantly reduced.

Visits by social workers are purposeful, and well recorded, with evidence of some strong direct work with children. Changes of social worker have affected the overall quality of relationship between social workers and children, although inspectors saw some effective work to build positive relationships with children and their families. The use of family group conferences is having a positive impact on children.

More work needs to be done to ensure that all children are visited within the required timescales, that they know about their entitlements and that more benefit from advocacy and independent visiting services. Permanence planning is not sufficiently robust in the majority of cases looked at by inspectors.

The quality of risk management is too variable. Resources to support children at risk are not always in place at the right time, and delay is not challenged sufficiently robustly. Responses to children looked after who go missing need improvement.

Most plans, including review of plans, address the health needs for the child but unreliable health data mean that the local authority cannot be confident that all children receive timely health assessments. Strengths and difficulties questionnaires are not used to understand and respond to the child's emotional and mental health needs. Too often, children experience delay in receiving support from CAMHS.

Educational outcomes for children looked after are improving overall. Children are progressing well between key stages. Personal education plans are mostly good, although plans for young people's learning beyond Key Stage 4 are not consistently effective.

Overall, placement stability is in line with similar authorities. There is a continuing shortage of foster carers, but existing carers feel they are increasingly respected as professionals who are part of the team around the child.

The quality of adoption work is improving and there are areas of good practice, but further work is required to ensure that these improvements are embedded across the whole service. Post-adoption support is a weakness.

The local authority is in touch with almost all care leavers. Personal advisers support

care leavers particularly effectively. While the local authority risk assess all accommodation, the stay for a few care leavers in bed and breakfast accommodation is too long, as is the wait for independent living accommodation

Inspection findings

49. There were 628 children looked after by West Sussex at the time of the inspection. The rate of children looked after per 10,000 children in 2013–14 was lower than the average for similar authorities. The number of children looked after has risen over the last 12 months by nearly 4%.

50. The percentage of children who are looked after under a voluntary arrangement under section 20 of the Children Act 1989 continues to be relatively high. The local authority is aware of this. Its analysis concludes reasonably that this is, in large part, due to the high number of unaccompanied asylum-seeking children and a recent increase in the number of disabled children with complex needs entering care.

51. There is close monitoring of pre-proceedings work to ensure that there is no delay in taking necessary legal action. The local authority recognises that this is an area that requires ongoing scrutiny. In a small number of cases where children have become recently looked after, action could have been taken earlier. In all other cases seen by inspectors, decisions that children should be looked after were appropriate, supported by strong direct work and with evidence of regular and effective management oversight. The views of children and families were captured clearly and informed plans.

52. The quality of work prior to and during care proceedings is good. The number of legal planning meetings is increasing. These are robust and the Public Law Outline is followed appropriately. Letters to parents before proceedings are clear and make good use of the clearly defined approach to casework to outline effectively the risks to children and what needs to happen to keep them safe.

53. Although timescales for care proceedings have not met the national target, the average length of care proceedings has reduced substantially, from 55 weeks in 2013 to 30 weeks currently. Social workers' court reports are generally of a good quality and accepted by the courts, reducing the risk of delay. However, the quality of viability assessments of family members is variable. While some are good, several assessments seen by inspectors did not provide a sufficiently thorough analysis of the potential implications of proposed placements, risking delay for children in achieving permanence (recommendation 2, 4, 5).

54. The use of family group conferences is becoming increasingly embedded and there is demonstrable evidence of its positive impact on children. This includes promoting increased contact for children with wider family members, including the paternal side of the family, even if children do not ultimately return to the care of their birth parents. The local authority maintains positive and productive working relationships with the judiciary and with Children and Family Court Advisory and Support Service (Cafcass). Cafcass reports improving local authority practice.

55. Plans for children to return home are appropriate and generally effective, although a minority of plans are not sufficiently specific about actions, timescales and responsibilities. Ongoing support is in place as appropriate, based on effective assessments and underpinned by regular management oversight, although placement with parent regulations have not been followed in a timely manner in all cases. More than half of the children and young people who have entered care as part of the Fostering Emergency Support Programme have been able to return home safely within agreed timescales.

56. Social workers' visits to children are generally purposeful and well recorded. Social workers see children alone when they visit. Inspectors encountered several examples of good or excellent work, including some very effective use of direct work tools such as the 'Three Houses' model, to engage and support children and their families. However, they also found that, too often, the regularity of visits does not meet requirements, either at the minimum frequency required by statutory guidance or, in a small number of cases, at a frequency fitting the needs and wishes of individual children. The local authority's own audits reveal that nearly one in five statutory visits to children were not undertaken within timescales in the 12 months up to September 2015. This performance level is partially explained by the disruption and movement of social workers in the recent service redesign. Improvements are being closely monitored and reported by frontline managers as staffing movements have stabilised (recommendation 2).

57. Changes of social worker, caused partly by the service redesign, have adversely affected the overall continuity and quality of relationships between social workers and children looked after. Several children spoken to by inspectors explained how they need more help to understand what has happened to them and why they are in care. Changes in allocated worker mean that it has been difficult to get clear, consistent support and information (recommendation 10).

58. Children and young people spoken to by inspectors had limited awareness of their entitlements or how to complain. More work also needs to be done to ensure that children are aware of, and have access to, the advocacy service. Where complaints are made, they are acted on properly and the vast majority resolved informally at an early stage. However, the authority does not collate and analyse complaints effectively in order to pull out themes and drive overall improvement (recommendation 10).

59. The independent visitor scheme is an area for improvement. Only 14 children currently receive support from an independent visitor. There is insufficient capacity to meet the needs of all those children and young people who may benefit from the service. The service is not sufficiently promoted by professionals during case planning and reviews. The local authority acknowledges this shortfall in support and plans are in place to increase the capacity and scope of the service.

60. The quality of risk management is variable and was good in only half of the cases tracked by inspectors. Good quality work was characterised by prompt identification and response to a range of risks faced by children. Effective safety plans involve all key individuals, including children and young people themselves. Good use of the clearly defined approach to casework helps to provide clarity and purpose of plans to manage, and reduce, risk. However, in several cases seen, resources to support children at risk were not always in place at the right time. Gaps in support, such as help to address risks relating to sexual exploitation, substance misuse and mental health, should have been challenged or addressed more urgently by professionals, including managers and independent reviewing officers (recommendation 2).

61. Several examples were seen by inspectors of effective return interviews with children who had been missing. However, overall, these interviews are not undertaken routinely and those that are undertaken are not always sufficiently independent or effective. This represents a failure to comply with statutory requirements and means that plans to protect children who go missing are not effectively informed by children's views and experiences (recommendation 8).

62. Most plans, and the reviews of plans, address children's health needs appropriately. Children are encouraged and supported to eat healthily and undertake sporting activities. Health assessments are not consistently undertaken in a timely manner and are sometimes undertaken during school hours. Monitoring of performance is affected by the unreliability of data collection systems. Recent work with health partners to resolve these data difficulties has yet to show impact (recommendation 9).

63. CAMHS provides a broad range of interventions from individual sessions to family therapy. In addition, they provide some helpful support to residential staff and foster carers and adopters, including individually tailored interventions. Those children and carers who receive support benefit from this and value it highly. However, too many children experience significant delay in receiving required support from CAMHS, waiting up to 28 weeks between referral and treatment (recommendation 9).

64. Strengths and difficulties questionnaires are not used as required by statutory guidance, either individually or collectively. This limits the local authority's understanding of and response to the emotional needs of children looked after. Plans are now in place to address this gap (recommendation 9).

65. The proportion of children looked after who make the expected progress between Key Stages 1 and 2 has improved significantly. For 2014–15, data held by the virtual school show that 86% made the expected progress in reading, 79% in writing and 71% in mathematics. These figures require further improvement and consolidation over the next few years.

66. The proportions of children looked after who achieve the national expectations at Key Stages 2 and 4 are improving, but remain too low. Too few make the

expected progress between Key Stages 2 and 4. Data held by the local authority for 2014–15 show half of all children looked after achieved the expected levels of attainment at Key Stage 2 in reading, writing and mathematics. At Key Stage 4, around one in five (22%) achieved five good GCSEs at A* to C, including English and mathematics. The attainment gap between children looked after and all children is narrowing but remains too wide, particularly when compared with statistical neighbours and national figures.

67. The local authority has worked hard to tackle permanent exclusions and there has been none for the last five years. This was an area for improvement identified at the previous inspection. Fixed-term exclusions have reduced and children are spending more time in learning as a result. In 2012–13, the proportion of fixed-term exclusions was 8.9%. This was a reduction from 12.6% in 2010–11 and lower than statistical neighbours or nationally.

68. The large majority of children looked after go to a good or outstanding school. Those who do not receive a level of support which means they are not disadvantaged by this. Good alternative provision is available for the small minority of children looked after who find it hard to cope at school, with nearly all of them receiving 25 hours a week of learning. Tailored specialist support is available for those children who need more support because they have emotional problems that create a barrier to learning.

69. Attendance of children looked after is carefully monitored and swift action is taken by managers where there are absences. Managers are fully aware of the small decline in attendance rates for children looked after in 2014–15, although the overall trend is one of improvement over the last three years. For example, in 2013–14, the proportion of unauthorised absences was 0.7% and the proportion of persistent absences was 4.7%, reduced from 0.8% and 7.2% respectively in 2012–13.

70. For the large majority of children looked after up to Key Stage 4, the quality of planning for and monitoring of learning by all stakeholders is good. The best personal education plans (PEPs) provide a clear insight into the child's learning and development. These plans typically show accurate learning targets such as clear small steps that children need to make to improve. The use of the pupil premium is consistent with PEP content. All appropriate parties are involved in the planning, including the child.

71. Planning to help children looked after progress between Key Stages 4 and 5 is not consistently effective. It is not always clear why a child has taken a particular course, apprenticeship or study programme and whether it is right for them. In several cases, reviews happened too early to help plan next steps and the course had started by the subsequent review, which meant that the decision was not scrutinised sufficiently well. Managers are fully aware of the need to increase the range and quality of progression and destinations for children looked after aged 16 and over. An improvement plan is in place, but

some of the measures in it will be difficult to demonstrate and it would benefit from further refinement (recommendation 4).

72. The virtual school has worked hard to improve the outcomes of children looked after. Data analysis and oversight of learning have improved. Managers now monitor more rigorously the progress of children and make sure that education provision meets their needs. The virtual school helps foster carers to understand how to support children in their care. Service plans for the education of children looked after, however, do not effectively summarise the key strengths and areas for improvement and contain too few measurable tasks and targets (recommendation 4).

73. A high priority is given to providing children and young people with opportunities to enjoy a wide range of hobbies and leisure opportunities suited to their individual wishes and needs. Carers are routinely and appropriately given delegated authority to make decisions on behalf of the local authority, such as when children want to stay overnight at a friend's house.

74. Children spoken to by inspectors feel safe and nearly all feel settled where they are living. One group of young people made it very clear to inspectors that they all felt that being in care had made a positive difference to their lives, enabling them to be more confident and settled and to progress at school and college.

75. Inspectors saw evidence of some very effective placement matches, but the rigour of matching seen in the local authority's adoption work is not yet consistently apparent for all children looked after. Case records, though usually up to date and demonstrating regular management oversight, do not always clearly outline the rationale for matching and other key placement decisions.

76. The local authority has developed a good range of available placement types, including the Fostering Emergency Support Programme, a well-established multi-dimensional treatment foster care scheme, and parent/child placements, which have provided some good outcomes for children. In-house provision is flexible and the local authority works diligently to provide continuity of care for children. Inspectors saw examples of concerted efforts to keep brothers and sisters together when it was in their best interests. The local authority is prioritising the need to recruit carers who can look after sibling groups. However, the rationale for decisions about whether brothers and sisters should remain living together was not always clearly recorded in children's individual case records.

77. Overall, placement stability is broadly in line with similar authorities. Foster carers report inconsistent though improving, quality of support from both family placement workers and social workers. They value the training that they undertake. Recent experiences of regular changes in allocated workers is a common concern. Overall, foster carers feel increasingly respected as fellow professionals and part of the team around the child.

78. The fostering panel operates effectively, providing suitable challenge and involving carers effectively. Assessments of carers are of consistently good quality. They are completed in a timely manner and contain sufficient detail and effective analysis to support placement planning. Annual reviews of foster carers are regular and address most of the issues they should. However, they do not always address training needs with sufficient rigour.

79. The large majority (83%) of children looked after live within West Sussex. For those who live outside the county, plans to arrange placements with the right support in place are carefully formulated and this leads to some improved outcomes for children. However, in a small number of cases, because it was not prioritised with sufficient urgency, the distance of the placement hampered the frequency of visits by professionals, and the planning to prepare young people for their next move or independence. Evidence of formal notifications to key agencies when children move out of county was not always readily available for inspectors to see. The local authority does, however, undertake some proactive work to meet the needs of children who are looked after by other local authorities but living within West Sussex, including those who go missing or are in need of health support.

80. The quality of care plans was poor in half of cases seen by inspectors. Common flaws included a lack of timeliness and plans that were not clear about who was going to do what, by when and with what intended outcome. Contingency planning is not always sufficiently detailed. The stronger cases had plans with clear accountabilities and timescales and represented children's and families' views well (recommendation 4).

81. Contact with family and friends is promoted actively and effectively for nearly all children. More needs to be done to overcome difficulties in enabling the small number of children who live outside the county to see family members as much as they might do if they lived nearer their home area.

82. Inspectors found a growing focus on tracking permanence in part due to the positive impact of the recently implemented permanence planning coordinator role. Plans for permanence are consistently considered appropriately early, by the second statutory review or earlier. The full range of permanence options are considered for children, including special guardianship orders (SGOs). Ten per cent of children who have left care in the last 12 months are now subject to an SGO. Nearly all of these orders were granted to foster carers with whom children had positive pre-existing relationships. Assessment and plans to support SGOs are appropriate in most cases, although not all support plans are sufficiently detailed and specific. A dedicated SGO team provides post-order support.

83. Permanence planning is not, however, sufficiently robust in the majority of cases. Weaker cases are hindered by a lack of overall urgency and drive. These cases require clearer targets for the implementation of actions and more consistently robust tracking of progress by managers and IROs. The formal

ratification of permanent placements was not always clearly recorded (recommendation 5).

84. IROs are actively involved in case discussions. They effectively promote children and young people's engagement in planning for their futures and inspectors saw several examples of effective challenge and escalation by IROs in order to progress plans. However, the level of rigour applied to monitoring and reviewing plans is not consistently strong. The IRO service's own self-assessment recognises this as an issue. Too many reviews do not lead to specific, time-bound actions, and delay is not consistently challenged or addressed with sufficient urgency. Only 81% of statutory reviews were held on time in the 12 months up to and including September 2015. The local authority is addressing these issues with an increase in IRO capacity, and increased oversight by the manager. The authority expects to see improvements during the next six to 12 months (recommendation 5)

85. The local authority has prioritised staff's cultural competence and diversity awareness effectively following an Ofsted inspection recommendation in 2013. The diverse needs of children were met effectively in the majority of cases seen by inspectors, including effective examples seen of timely life story work and of care and support that was sensitive to children's specific needs, including religion, culture and sexual identity. In a small number of cases, opportunities were missed to address needs arising from diversity, and work to help children gain a strong sense of identity is more likely to be undertaken for younger children looked after.

86. The Children in Care Council (CiCC) is led by an articulate and thoughtful group of young people. It has undertaken some imaginative and valuable work, including quality assurance visits to children's homes and awareness-raising visits to local judges and barristers. It took a lead role in the planning of a recent event to celebrate the many achievements of children looked after. A mix of informal and formal meetings is designed to encourage more children and young people to become active in the CiCC. The local authority acknowledges that there is more to do to ensure that the CiCC is representative of the wider children looked after population, including those children who live in distant placements. It also acknowledges the need to increase the influence and involvement of the CiCC in service design.

The graded judgement for adoption performance is that it requires improvement

87. Adoption is now considered at an early stage for all children. A permanence planning coordinator was appointed in May 2015 and monthly permanence tracking meetings have been implemented since August 2015. Adoption managers have recently become part of early planning for children becoming looked after. These developments support early family finding, and adoptive

placements are now identified quickly for children who need them. The authority ensures that children's needs arising from diversity are thoroughly considered in the family finding and matching processes. All 26 children who are currently waiting for adoption have an identified adoptive family.

88. Ineffective oversight by managers and IROs has meant that progress on rescinding placement orders for some children whose plans have changed away from adoption has been too slow. Children have therefore not been legally secured in permanent placements in a timely way. However, it is positive that these children have remained in the same placements and that alternative legal permanence is now being pursued (recommendations 5, 11).

89. The timeliness in which children are adopted is showing recent improvement. In the most recently published adoption scorecard, for the three years 2011–14, the local authority's average time between children entering care and moving to adoptive placements was 586 days. This is against an average for England of 628 days. Local authority data for the three years to the end of September 2015 show a reduction in this figure to 493 days, which is close to, though still slightly above, the government threshold for 2012–15 of 487 days.

90. The percentage of children adopted in 2014–15 was 13% below the national average of 17%. The number of children being adopted and placed for adoption has reduced in line with the national picture. There have been children placed over the last year for whom it has taken longer to find adoptive parents. An analysis undertaken by the local authority has identified an increase in the number of children who are likely to have a plan for adoption in 2015–16.

91. Some improvement is also evident in the time between the local authority receiving court authority to place a child and agreeing a match. The most recently published adoption scorecard shows the local authority's three-year average for 2011–14 was 172 days, against an England average of 217 days. The local authority's own figure for this indicator for the three years to September 2015 is 162 days. Although this is a slight improvement, it is significantly above the government threshold for 2012–15 of 121 days.

92. The process for the recruitment and assessment of adopters is in line with national arrangements. Prompt and informative initial responses and timely preparatory training is effective in engaging and developing prospective adopters. In the majority of cases, assessments are thorough, identify prospective adopters' strengths and vulnerabilities, and provide a sound basis for supporting matching decisions, although greater clarity could be provided on future support needs. However, too many assessments take more than six months to complete and performance monitoring and management of this is not effective (recommendation 2).

93. Careful matching of children with prospective adopters takes place at matching meetings. These meetings fully consider how prospective adopters will meet the needs of the children, although the formal recording of the rationale for

decisions could be more clearly evidenced in some cases. Inspectors saw a good example of a birth parent being involved in matching decision-making. When no in-house adopters are available to meet the needs of children, timely approval is given to extending family finding to the local consortium and, where necessary, nationally.

94. West Sussex approved 21 adopters in the year to September and currently has 17 adopters waiting to be matched. Seven of these have been linked with or identified as suitable for West Sussex or local consortium children. The majority of the adopters waiting are approved for younger children. Support groups are in place for adopters while family finding continues. The authority shares adopters' profiles with the local consortium and also utilises adopter-led national processes where necessary.

95. The local authority is currently targeting its recruitment to increase the pool of adopters who are able to take older children, sibling groups, those from minority ethnic backgrounds and children with more complex needs. To date, the local authority has placed seven children in fostering for adoption placements, with one placement currently ongoing. The adoption panel is concerned that fostering for adoption needs to be better explained to all prospective adopters.

96. The adoption panel has a suitably qualified and experienced independent chair. Recent recruitment has successfully increased the diversity and experience of the panel membership. The panel is well organised and has benefited from the recent appointment of a permanent full-time adviser. Feedback from participants is consistently positive, with the use of an adopter to greet carers being particularly valued. The adoption panel effectively scrutinises applications for approval and matching, with the reasons for recommendations being clearly evidenced. The panel feeds back practice issues to the local authority, including concerns about the variable quality of child permanence reports and adoption support plans. However, this feedback is not yet undertaken consistently and systematically as a driver for continuous practice improvement. The local authority has recruited more staff to permanent positions to reduce the reliance on independent workers to complete reports, which were of variable quality.

97. Where there is a recommendation for adoption to be the plan for a child, the agency decisions maker's (ADM) scrutiny of this is timely. The ADM's decisions show that an appropriate range of documents have been considered in reaching a decision. The rationale for the decision is also clearly set out in sufficient detail.

98. Social workers provide effective support to adopters when children first move to their care and the planning and management of the transition is thorough. Foster carers are integral to this work, preparing children well and contributing effectively to the placement move. Inspectors saw good examples of sensitive practice facilitating birth parents meeting adoptive parents and contributing to

life story work. This will give children positive information about their history and assist the development of theirs sense of identity.

99. Life story work is developed in collaboration with adopters. In examples seen by inspectors, the work was age-appropriate and gave clear information about and sensitive explanation of the child's journey. Good-quality later life letters are provided to help young people understand the planning and significant events in their lives when they are older.

100. The provision of post-adoption support is not always timely or systematic. Initial requests for support are responded to slowly. When assessments are undertaken, the quality and consistency is variable, with too many taking too long to complete. Adoption support plans are not sufficiently outcome focused, and do not have clear timely measures to underpin progress. The plans are not reviewed effectively (recommendation 12).

101. Management oversight of requests for adoption support and therapy is not robust and the multi-agency coordination of those requests is not yet sufficiently developed to ensure consistent and timely service provision. Therapeutic support is available but the quality of some services is variable, thus reducing impact for children and adopters. To address this problem, training has recently been undertaken to improve the capacity of social workers to offer therapeutic interventions (recommendation 12).

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

102. All care leavers who transfer to the care leavers' service aged 18 have pathway plans, though a minority of these do not have enough detail to provide a full picture of care leavers' needs. Overall, pathway planning for 16- and 17-year-olds is not sufficiently sharp. In response, managers have introduced a pre-pathway plan that they anticipate will provide a better starting point for determining care leavers' needs. Social workers support young people well as they leave care, and help them to get to know and trust their personal advisers. However, social workers who act as personal advisers for these young people also chair the reviews of their pathway plans. This does not offer sufficient independent oversight of plans or comply with recent case law (recommendations 4, 5).

103. Most care leavers understand and value the purpose of meeting advisers to review their progress. They feel that personal advisers listen carefully, record their views well and act on these. Personal advisers review pathway plans with care leavers every six months and effectively support care leavers to access a range of support services. The result is that care leavers feel cared for and have someone they know they can rely on. One care leaver reported:

'nowadays people always ask me how I survived the care system, but I truly believe that I only survived because of the care system.'

104. Personal advisers maintain frequent contact with care leavers between reviews. They are good at recording and managing the risks that care leavers can present as they learn to become independent, such as difficult life situations or unacceptable behaviour. They use the casework model to help with this. Personal advisers encourage care leavers and praise them when they do well. They receive a range of training, including on child sexual exploitation, and use this to help keep young people safe. Personal advisers also monitor closely the progress and outcomes of care leavers who have been in custody or who have moved out of the area. Overall, personal advisers have effective oversight and a thorough understanding of the needs of care leavers.

105. Personal advisers and managers link well with other agencies, including health providers and the police. Care leavers say that the support they receive helps them to feel safe. Staff record care leavers' experiences in sufficient detail. Personal advisers are in touch with almost all care leavers. For the four young people the local authority is not in touch with, this has been the choice of the young people.

106. Pathway plans and reviews for most care leavers aged 18 and above are good, and better than those for care leavers below 18 years. Care leavers are fully aware of their plans. A very few do not value the written plans, though they do value the personal support they receive. The best pathway plan reviews show well defined targets that advisers monitor carefully and indicate clearly when achieved. These plans contain detail on the care leaver's circumstances and appropriate actions to move the situation on by the next review. They demonstrate a particularly good, deep understanding of care leavers' needs and involve them fully in the process. A minority of plans lack direction from review to review and are unclear as to whether actions have been resolved or contain limited information on the care leaver's education pathway.

107. Mental health provision for care leavers and transitional arrangements for care leavers to access adult services are good. Personal advisers make sure plans and reviews include useful dialogue about staying healthy and dietary requirements. They challenge care leavers to help them live healthy lifestyles, with the impact of this being evident in plans. All young people have clearly recorded medical histories. The local authority provides a health passport to care leavers to ensure that they have a good understanding of their health history. Personal advisers provide good advice and support for care leavers' sexual health, helping them understand the importance of healthy relationships. West Sussex provides a range of drop-in centres and online counselling for care leavers. Staff at the eight 'FindItOut' centres spread across the county have a good range of experience and expertise to work supportively with care leavers who drop in.

108. Personal advisers are adept at working with the diverse cultural needs of care leavers. For example, inspectors saw some good pieces of work undertaken in helping those who are asylum-seekers in gaining English language skills.

109. Most care leavers (85%) live in suitable accommodation. This is an improvement from 78% in 2013–14, when the figure was below that of similar authorities. Staff actively promote the 'staying put' policy, and 43 of 51 young people eligible to remain with their foster carers beyond the age of 18 do so.

110. In most cases, personal advisers effectively facilitate care leavers moving into supported accommodation. However, for a small minority of care leavers, the local authority is too slow to facilitate their move from supported accommodation on to independent accommodation. A very small minority of care leavers stay in emergency bed and breakfast accommodation for too long. When inspectors explored this with the local authority, managers were aware of the difficulties and had risk-assessed young people's circumstances. However, this use of bed and breakfast accommodation remains unacceptable. Four emergency beds are now available with 24/7 support, although this provision was introduced only very recently. New arrangements will prioritise independent accommodation for care leavers (recommendation 7).

111. Not enough care leavers go into education, training and employment. The proportion who are not engaged in education, employment or training (NEET) aged 19 and over was high at 45% in 2013–14. This was higher than statistical neighbours, at 41% and the national figure of 38%. The NEET figure has improved recently and was 38% at the time of the inspection (recommendation 6).

112. The local authority provides an insufficient range of opportunities for care leavers to gain employment or move on to further training, although managers are working with the virtual school to improve pathways for young people. Too few care leavers follow apprenticeships or go on to higher education. The local authority has recently started to address this (recommendation 6).

113. The number of apprenticeships for care leavers has recently increased, and the service manager for care leavers has recently secured an offer of apprenticeships through a national retail chain. There are also five care leavers with apprenticeships in the local authority, one of whom has gone on to gain a permanent position.

114. In 2013–14, only 4% of care leavers went on to higher education compared with 8.3% in statistical neighbours and 6% nationally. A care leavers' bursary of £2,000 is available for those who enter higher education. Overall, although there are examples of care leavers who have overcome significant barriers and challenges to progress in education, not all care leavers have been helped to fully appreciate the importance of education and skills (recommendation 6)

115. Care leavers are aware of their financial entitlements. The setting up home allowance exceeds the minimum set out in statutory guidance. Personal advisers make sure care leavers can access their financial entitlements.

116. Care leavers spoken to were clear about how they would make a complaint, but not sufficiently aware of the local authority pledge for care leavers. The 'your rights' website on their entitlement is understood by care leavers and most find it useful. The website provides information to care leavers on their entitlements. Care leavers are able to access the internet through their own devices or they can use the internet access available in the 'FindItOut' centres.

Leadership, management and governance	Requires improvement

Summary

The relatively recently appointed senior leadership team, led by the Executive Director of Care, Wellbeing and Education (statutory DCS) and Director of Family Operations, has implemented an ambitious and comprehensive service redesign and improvement plan at pace in this large local authority. These changes are producing a range of improvements across the whole service that is addressing a history of weak practice.

Despite these improvements and the strong leadership, there has not yet been sufficient impact on the effectiveness of frontline management. Frontline managers are not always offering the oversight of work needed to ensure that work with children and families is of consistently good quality. As a result, practice seen during the inspection was still too variable.

Not all recommendations from the 2013 inspection of the arrangements for the protection of children have been acted on effectively, including recommendations in relation to the timeliness and effectiveness of child protection plans.

The service redesign has introduced significantly more front line management capacity, alongside advanced practitioners to directly support social workers in improving their practice. Social workers welcome these changes, along with the comprehensive workplace-based training and development opportunities accompanying the new service model. They feel supported by managers and report that senior managers and leaders are visible and responsive. The commitment to the clearly defined approach to casework was in evidence across the service, from early help to care leavers and in quality assurance arrangements. The model was initially introduced in 2013 and full impact is not expected for another year as workforce changes and an extensive staff development programme continue to improve its prevalence and impact.

'Giving children the best start in life' is one of three core council priorities, with strong cross-party political support and strengthened strategic partnerships. The impact of this is evident in the recently expanded and improved targeted early help offer that is being delivered across the county and is well received by partners.

Quality assurance and performance management arrangements are improving and beginning to deliver a picture of practice, with the resultant action plans addressing areas of weakness. Case file audits undertaken alongside social workers are informative, robust, and are beginning to drive practice improvement. The Corporate Parenting Panel is developing its work with the Children in Care Council (CiCC).

Commissioned services are not always monitored effectively to assess whether they are delivering the specified outcomes for children.

Inspection findings

117. The Chief Operating Officer (COO) has a clear understanding of the challenges facing children's social care and the service improvement priorities. The COO effectively holds the independent chair of the LSCB to account through regular meetings. The DCS has an authoritative oversight of frontline practice, with effective mechanisms in place to receive performance information and evaluate the progress of improvements.

118. The views and influence of children, young people and families were prominent in the recent service redesign. Attention to cultural competency in social workers assessments and interventions was evident in the large majority of cases seen by inspectors. This indicates that senior leaders understand the importance of ensuring that the specific needs of minority groups in the county are well represented in early help and statutory interventions.

119. The role of Executive Director of Care, Wellbeing and Education incorporates the statutory responsibilities of the DCS role alongside the role of Director of Adult Social Services. No formal local test of assurance has been undertaken as set out in statutory guidance. However, both the DCS and the COO have an awareness of the risks associated with this arrangement, and this is discussed at their regular meetings. The local authority has sought advice on this issue from other local authorities with similar arrangements to assure themselves that the DCS has the necessary capacity to exercise her statutory functions. The local authority has also ensured that the DCS is supported through the appointment of a highly experienced Director of Family Operations.

120. Both the Lead Member and the Leader of the Council have a well-informed overview of developments and improvements in children's services. They understand the importance of their influence in supporting these. There is strong ambition across corporate and political leaders to producing enduring service improvements and better outcomes for children. This is clearly shown in the significant additional financial investment made by the council in children's services.

121. Strengthening strategic partnerships facilitate effective governance arrangements. The Start of Life Partnership Board (SLPB) embraces statutory children's services, the 'Think Family' programme and the cross-partnership early help offer. This allows clear partnership oversight across the entire spectrum of children's services.

122. The targeted early help offer is provided through six county-wide family support networks that deliver coordinated multi-agency services tailored to the individual needs of families. Early help plans have increased significantly in volume over the last year. Cases seen by inspectors demonstrated that plans and associated interventions are of a good quality and are outcome-focused.

123. The local authority holds detailed data to aid its understanding of local links between deprivation and higher need. However, no data are available on children living in families affected by parental mental illness, domestic violence and substance misuse other than for those children subject to a child protection plan where these risk factors are evident. The joint strategic needs analysis contains limited information or analysis of priority areas affecting children. The partnership between the Health and Wellbeing Board and the SLPB would benefit from greater clarity about joint priorities and the respective responsibilities of each in progressing these.

124. Performance management data are available both at team level and across the service. Weekly reports allow frontline managers to identify outstanding work such as overdue statutory visits or assessments quickly. Performance management of the 'Think Family' programme is robust, with the improvements made by families verified by independent audits. An integrated range of performance management measures has been recently introduced for targeted early help provision and is expected to provide valuable progress measures and outcome data.

125. Some areas of performance information require further development. Oversight of performance in the adoption service is underdeveloped, particularly the availability and impact of post-adoption support. There is also insufficient monitoring and analysis of the frequency of visits to and reviews of plans for children in need (recommendations 2, 12).

126. A monthly senior management quality assurance meeting scrutinises key indicators to assess timeliness and trends. This is currently 'focusing on the fundamentals' of practice such as chronologies, strategy meetings and case management oversight. Areas of concern are identified for further examination through the learning audit programme. This programme has begun to deliver a picture of practice, and action plans are put in place to address identified areas of weakness. The local authority has plans in place to repeat the learning in the future to assess the progress against these plans. The audits themselves are undertaken alongside social workers, they are informative and robust and provide a realistic picture of practice; a view shared by inspectors as evidenced through case tracking during the inspection.

127. Elected members and the LSCB receive performance information from the monthly quality assurance meetings. A quarterly performance meeting with all staff is effective in advising the wider children's workforce of important themes and priorities and supporting them to make changes in practice.

128. Although there is a commissioning strategy for external placements for children looked after, there is no overarching strategy for the commissioning of children and young people's services. Not all current provider services are effectively performance-managed. This means that the local authority is not ensuring that all commissioned services are satisfactorily meeting the needs of children. Examples were seen of more recent commissioning that was more effective.

This included a wide-scale redesign of CAMHS, underpinned by an extensive needs analysis and effective joint commissioning with the county's three clinical commissioning groups. This will lead to a new commissioned framework of services in 2016 that will provide greater capacity for children and young people to access mental health support at an earlier stage of their difficulties and quicker access to treatment for those children with more serious mental illness (recommendation 9).

129. The local authority is able to source sufficient choice of placements for children looked after through a combination of its own resources and an effective, needs led, sub-regional commissioning framework.

130. The Corporate Parenting Panel (CPP) is well established and influences other strategic bodies. For example, the lead member raised a challenge at the Health and Wellbeing Board in relation to concern from the CPP about a lack of focus on children looked after in clinical commissioning group commissioning plans. This resulted in an additional post being created with strategic oversight of provision for children looked after across the partnership. In addition to the Health and Wellbeing Board, the lead member also sits on the SLPB, providing consistent representation of the interests of children looked after.

131. The CPP has seven current priorities which are effectively monitored in regular progress reports. Prominent among the priorities is improving the educational attainment of children looked after through close scrutiny of the impact of the Virtual School. The Multi-agency Children Looked After Improvement Group reports to the CPP on the delivery of its quality improvement plan. The CPP meets formally with the CiCC three times each year. The CiCC has some influence on the CPP's priorities, though the CPP would welcome greater challenge from the CiCC.

132. The engagement of the local authority with Cafcass and the judiciary has significantly developed. The local authority is an active participant in the Local Family Justice Board. Cafcass reports strong and positive relationships with senior managers. At the point of the inspection, the length of proceedings stood at 30 weeks, though delays were not judged by inspectors to be due to any failing by the local authority.

133. The vast majority of complaints are resolved informally, and individual learning points are provided to workers. However, overall learning from complaints is not used effectively to inform learning and improvement. For example, the local authority does not understand the dominant themes arising from complaints by children looked after, which would enable the CPP to explore and challenge these.

134. Workforce development is supported by a service redesign built on a clearly defined approach to casework. Evidence of the use of this approach was widely seen across the whole service in social workers' practice and in management supervision. Extensive workforce training and development is provided to build

the confidence of workers in the use of the approach. A workforce development team, led by the principal social worker, continually evaluates the impact of the approach on practice.

135. Considerable investment has been made in increasing management support, coaching and mentoring for social workers. During the inspection, some impact from these changes was becoming apparent, but had not yet overcome a history of variability in practice standards and outcomes for children.

136. The vacancy rate for social workers is 19%. However, this is in the context of an expansion of the social work workforce as part of the redesign, although not all of the additional posts have yet been filled. The large majority of social workers have been employed by the local authority for three or more years, indicating a committed and predominantly experienced frontline workforce. Non-social-work-qualified staff have access to a supported traineeship programme to obtain social work qualifications. Based on current recruitment activity, the local authority reasonably anticipates that social work vacancies will significantly decline in the near future.

137. The principal social worker capably promotes exacting practice standards for the recruitment, development and assessment of social workers with reference to the employer requirements. In their first year of practice, social workers' professional development is overseen by the local authority's 'social work academy'. Social workers value the support this provides.

138. Caseload sizes are manageable, at approximately 20 cases or fewer, and the local authority plans that these will reduce further once all current vacancies are filled. Significant additional investment has been provided to increase administrative support for social workers. Social worker exit interviews reported that a significant factor in social workers seeking employment elsewhere was the lack of time to undertake direct work with children and families. The early impact of the additional investment was appreciated by social workers seen during the inspection.

139. Although still requiring improvement, management oversight of casework is improving in both frequency and quality. Managers pay careful attention to non-casework supervision areas, particularly training and development, and workload management. Reflective supervision and appreciative enquiries were evident in a majority of cases seen. Social workers spoke highly of the quality of their supervision. Sickness levels are very low indicating that social workers feel supported and capably managed.

140. Strategic coordination, intelligence collation and analytical capacity of the oversight of child sexual exploitation are in their infancy, although arrangements to improve capability and capacity have been recently introduced. The local authority recognises that not all missing interviews are undertaken or not completed in a timely manner, with a variable quality of helpful intelligence provided when they are completed. The missing and child

sexual exploitation subgroup of the LSCB is addressing these shortcomings, although progress is comparatively slow (recommendation 8).

141. The threshold for the management of serious incident notifications is appropriate. The action plan for a published serious case review took too long to complete. A subsequent case review identified similar issues, indicating lessons from the earlier review had not been widely absorbed. Of particular note was poor attendance of health agencies at strategy discussions, which inspectors also found to be a feature of casework during the inspection (recommendation 3). However, there was evidence that staff and managers were aware of the findings from a more recent serious case review action plan.

142. The designated officer effectively screens allegations against those working with children, which require investigation at the point of referral, providing valued consultation, particularly to schools. However, the progress of investigations is not regularly tracked and outcomes on cases are not recorded in a timely fashion. In addition, there is no effective overview of investigations, meaning that the opportunity to identify themes emerging from these is lost (recommendation 13).

143. West Sussex is a Home Office priority area for the Prevent initiative. Strategic and operational arrangements are effectively aligned, with appropriate agency representation and effective links with the LSCB. Fortnightly meetings are held with Prevent leads to review individual cases alongside monthly Channel panel meetings, which considers high risk cases. Case management interventions, information sharing and the analysis of trends and themes are effective.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement

Executive summary

The governance and structure of the Local Safeguarding Children Board (LSCB) meet statutory requirements. The Board has an established independent chair and appropriate agency membership of sufficient seniority.

The priorities of the Board do not align with other strategic partners nor have they been influenced by trends identified from the Board's data set. Progress against some areas of the three-year business plan has been slow. Although the plan is clear and concise, it is insufficiently detailed about the measurable impact on children and young people. Subgroups drive core business and are effectively held to account through the executive group.

The Board's performance data is underdeveloped. It does not provide a clear picture of the journey of the child or the application of thresholds. This limits the Board's oversight of frontline practice. Local profiles of children missing and those at risk of child sexual exploitation and female genital mutilation are not well enough understood. A high number of actions in the recently refreshed child sexual exploitation strategy is yet to be completed.

Multi and single-agency audits are used to good effect to monitor the implementation of new procedures and to identify areas of concern.

The Board does not have a good enough understanding of the training needs of partners. There is limited multi-agency participation in some of the Board's training, and some training has been cancelled because of low numbers.

Communication is a clear strength of the Board. It has forged strong links with other strategic groups and developed staff consultation events to identify how best to cascade key messages to frontline practitioners. The Board has reviewed its website and refreshed its electronic policies so they are fit for purpose.

Lessons learned from a past serious case review did not lead to sufficient change in practice, with the same issues found in a subsequent case review.

The annual report provides examples of lessons learned from sub-group activity over the previous year and case studies demonstrating impact, but overall lacks sufficient analysis of safeguarding activity in West Sussex. This is a missed opportunity to share what has been learned with both the partnership and the public.

Recommendations

144. Ensure that all relevant partners provide performance data covering the whole journey of the child, to enable the Board to monitor the use of thresholds and key stages of decision-making.

145. The LSCB should improve its understanding of the local nature and prevalence of child sexual exploitation, children missing, female genital mutilation, forced marriage and trafficked children to support the development of strategic multi-agency responses in these areas.

146. A comprehensive training analysis should be completed with partners to ensure that the Board's training offer reflects the needs of partners and is responsive to changing demands. Current arrangements for the booking of training should be reviewed to ensure that these enable the board to meet demand effectively.

147. The LSCB should evaluate the training delivered to ensure that the impact on practice over time is fully understood and that it contributes to improved safeguarding practice across the partnership.

148. Ensure that the LSCB annual report fully reflects the activity of the previous year, including an analysis of changing patterns and trends in child protection categories.

Inspection findings – the Local Safeguarding Children Board

149. West Sussex Safeguarding Children Board is independently chaired and has appropriate agency membership of sufficient seniority to make key decisions and commit resources. The chair is highly regarded by partners and is held to account through bi-monthly meetings with the executive director and chief operating officer.

150. A strong constitution sets out clear roles and responsibilities and underpins all aspects of the Boards work. The chair has challenged irregular attendance and partners now show strong commitment through attendance at meetings and subgroups. Membership of the Board reflects local issues. For example, Home Office Immigration Enforcement are active participants, reflecting the presence of Gatwick airport within the Board's area. All agencies contribute to the budget, which is sufficient to enable the Board to deliver its programme. Board membership includes two lay people to provide strengthened independence.

151. The Board is reflective in its self-evaluation and makes changes as necessary to strengthen its scrutiny and challenge function. The scrutiny calendar enables the Board to oversee and monitor a broad range of safeguarding work including multi-agency public protection arrangements (MAPPA), MARAC and Prevent. Scrutiny reports give service updates as well as progress against lessons learned from serious case reviews and identify any actions required by the Board. The Board has enhanced its level of scrutiny of partners whose self-

evaluations give cause for concern with the introduction of specially convened panels to oversee action plans in these cases. The audit tool has been amended to include child sexual exploitation, and plans are in place to include female genital mutilation in future audits.

152. The chair has worked hard to forge effective links with partners, which have enabled respectful and purposeful challenge. Consultation events have helped the board to understand how best to cascade key messages to staff. As a result, social workers were clearly able to articulate lessons learned from serious case reviews to inspectors. One of the lay members has worked with the Board to review its website to ensure that it is more user-friendly.

153. The Board links with and influences other strategic groups. The independent chair sits on the Health and Wellbeing Board and the SLPB. The chairs of these two boards are non-voting members of the LSCB. A clear written protocol underpins these links. The Board presents its annual report to the SLPB and to the Police and Crime Commissioner, helping to keep a sharp focus on key safeguarding issues for children. These links have helped the Board to secure funding from the Police and Crime Commissioner for an analyst focusing on child sexual exploitation across West Sussex.

154. The Board's business plan covers a three-year cycle. Some areas have been slow to progress, with actions carrying forward to the following year. The plan's priorities do not align with other strategic groups and have not been influenced by trends or concerns identified through performance data. The delivery of the work plan through core subgroups is supported by clear terms of reference detailing how groups link with one another to progress work planning. Delegation of authority to each group ensures that decision-making is at the right level. The executive group has strong oversight of the progress of the subgroups through a formal reporting structure, and escalates areas of concern to the Board.

155. A formal challenge log details specific concerns, the action taken and the outcomes of the challenge. However, the current log does not reflect all challenge made through the Board. For example, concerns relating to changes of social worker raised by health partners received a detailed response from children's services but are not included as part of the formal log.

156. The pan-Sussex policies and procedures group ensures multi-agency safeguarding procedures are fit for purpose and responsive to lessons learned from case reviews. This strengthens the sharing of procedures and policies, skills, knowledge, resources and learning and helps to ensure consistency across the three authorities. The Board has adopted the pan-Sussex safeguarding procedures while maintaining guidance specific to local circumstances in some areas. Policies and procedures are clear, concise, and readily accessible on the Board website. The website highlights key changes and clear date-stamping enables practitioners to quickly identify amendments to procedures.

157. The Board has demonstrated clear commitment to strengthening the voice of the child through making this a key priority of its business plan. Work has been slow to progress. However, there are established links to the youth cabinet, who have identified e-safety as an area of concern. It is too soon to measure the impact of this.

158. Current performance information is underdeveloped and does not provide a clear picture across the journey of the child. The current dataset is insufficiently multi-agency, limiting the Board's ability to evaluate safeguarding activity across the partnership. There is no benchmarking of data against statistical neighbours or national figures, meaning the Board is unable to understand how well it is performing against other areas. The Board's quality assurance subgroup recognises the shortfalls in this area. A revised performance framework has been agreed but is not yet in place, (recommendation).

159. The quality assurance subgroup uses both multi-agency and single-agency audit reports to review and understand frontline practice. Multi-agency child protection audits are undertaken every two months to evaluate the impact of practice and identify where improvement is required. Quarterly thematic audits focus on particular practice areas and monitor the implementation and impact of new procedures. For example, a focused audit following the introduction of new assessment tools for neglect identified that the tools needed to be adapted for use in assessing disabled children. Audit activity results in action plans to improve practice. However, these are of variable quality and do not always lead to measurable improved outcomes for children.

160. The Board recognised that the quality of responses to the section 11 audit was variable. Those considered poor were discussed directly with the agencies concerned at a special panel meeting. This has informed future practice and an agreement that the next section 11 audit will include additional areas, such as female genital mutilation.

161. The coordination of training is underdeveloped and there is no needs assessment to identify multi-agency training needs. As a result, the Board cannot assure itself that it is delivering sufficient training in the correct areas to meet the needs of its partners. The practice improvement sub-group now oversees training. There is only a limited pooled resource of trainers across the partnership, demonstrating a lack of multi-agency commitment to the Board's training programme. Low attendance rates have led to some training being cancelled. The electronic booking system is not fit for purpose, and does not identify the full demand for training. Evaluation of the impact and quality of training has been limited due to the training manager post being vacant. There is no effective mechanism in place to evaluate the long-term impact of training (recommendation).

162. The case review sub-group operates to a clear written multi-agency protocol. There has been one serious case review led by West Sussex and two led by other LSCBs that have involved West Sussex. Decisions to complete serious

case reviews are well considered and reviews are completed when the statutory criteria are met. The board adopted the Social Care Institute for Excellence methodology for undertaking its serious case review, resulting in a comprehensive action plan. However, progress against the plan has been slow.

163. Lessons learned from the serious case review had not impacted sufficiently on frontline practice, with the same practice issues being found in a subsequent case review. This was particularly in relation to health partners not being sufficiently well involved in strategy discussions; inspectors also found this during this inspection. The Board has recognised these deficiencies, with the result that lessons learned from the serious case reviews led by other LSCBs have been effectively disseminated with concise plans swiftly executed.

164. The work of the child death overview panel is of high quality. The annual report is clear and detailed in its content and analysis. The panel identifies modifiable factors and actions are implemented to good effect. For example, when co-sleeping was identified as a modifiable factor targeted training was delivered to professionals and a media campaign was undertaken. Subsequently the number of child deaths where this is a factor has reduced.

165. The board has reviewed and refreshed its response to child sexual exploitation, adopting the pan-Sussex strategy. The strategy is comprehensive but is in its infancy with a high number of actions not yet completed. There is extensive work being undertaken relating to child sexual exploitation, missing children, female genital mutilation, child trafficking and forced marriage on a pan-Sussex basis. However, the West Sussex board does not yet have a comprehensive understanding of the local picture because there is insufficient information to fully understand the reasons for children going missing or to monitor the effectiveness of interventions (recommendation).

166. The Board has established a formal missing and child sexual exploitation (MACSE) subgroup within its structure. This brings together information on missing children and child sexual exploitation. The operational meeting is effective, identifying, monitoring and sharing information relating to children who go missing and/or at risk of sexual exploitation. Partners prioritise the meeting with strong representation and attendance.

167. The most recent published annual report is for 2013–14. The report describes the activity completed during the previous year in some detail and does evidence some lessons learned. It includes case studies detailing impact, and information about key achievements. However, there is insufficient detailed or robust analysis of partners' performance or lessons learned from audit activity. The 2014–15 report has similar weaknesses, though was still in draft form at the time of the inspection (recommendation).

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 nine of Her Majesty's Inspectors (HMI) from Ofsted.

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