Wiltshire Council
Review of Support and Safeguarding
Summary Findings

Report

May 2023

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1 Introduction

In June 2022, Wiltshire Council commissioned the Institute of Public Care (IPC) at Oxford Brookes University to undertake a follow up[1] review of Support and Safeguarding Services across the county including to explore the extent to which services were continuing to improve on a journey from 'good' to 'outstanding[2]'.

The review was undertaken between July 2022 and February 2023 and it has included the following staged elements outlined below, together comprising a highly comprehensive review including analysis of almost 200 individual child case files and over 55 in-depth interviews with staff and stakeholders.

Stage	Element	Timescales
One	**Review of the available administrative and performance data** including comparing Wiltshire with other similar authorities & Ofsted standards as applied recently	July - August 2022
	Sharing this information with a range of staff groups working in all 5 locality teams to consider the story behind these trends and suggest questions for a 'deeper dive'	September - October 2022
Two	**An in-depth 360 review of the integrated 'front door'** (including multi-agency safeguarding hub or MASH) into Support & Safeguarding Services incorporating: • Observations of front door practice and review of key documentation over several days • An in-depth review of 34 recent child 'contact' case files • Interviews with 8 front door team members	August – September 2022
Three	**A review of decision making at key stages of a child's journey** through Support & Safeguarding Services by dip sampling recent case files where there is a decision to proceed to a child protection case conference (20); not to proceed to a child protection case conference (20); that a child should be subject of a child protection plan (20); and to end a Child Protection Plan (20). A total of 80 recent	October – November 2022

[1] An earlier review was undertaken in 2019
[2] As defined by Ofsted

Stage	Element	Timescales
	'decisions' were examined (16 per locality), including with reference to all the information on a case file.	
Four	**An in-depth review of whole child journeys** through Support & Safeguarding Services through dip sampling and auditing recently closed Support (40) and Safeguarding (40) cases. 8 of each type of case file were sampled in each of the 5 locality teams/areas.	December 2022 – January 2023
	Interviews with 28 council practitioners (social workers, family support workers, team managers) from all 5 locality areas.	October – November 2022
	Interviews with 21 professional and family stakeholders including from all major statutory and voluntary sector partner agencies and council departments.	February 2023

A series of detailed reports have been generated in relation to each of these stages and elements as the review progressed, and their findings are both collated in the summary sections below and embedded as full documents in Appendix A to this report.

2 Findings regarding child and family presenting needs and overall 'demand' for support and safeguarding

2.1 Overall demand rates

In the early stages of this project (Autumn 2022) Wiltshire's performance data suggested very positive overall trends in demand including:

- A sustained and stable post-Covid re-growth in the number of 'contacts' with the Integrated Front Door (incorporating the Multi-Agency Safeguarding Hub, MASH).
- A rate of referrals to children's services similar to statistical neighbours.
- Rates of children looked after and children starting to become looked after in line with many 'outstanding'[3] local authorities demographically alike to Wiltshire.

Table 1: Wiltshire and outstanding local authority rates of children looked after and children becoming looked after per 10,000 population

Authority	Rate of children looked after at March 2022	Rate of children becoming looked after (2021-2022)
Essex	36	14
Hertfordshire	38	14
North Yorkshire	38	13
Wiltshire	**41**	**14**
Cornwall	48	21
Hampshire	61	22
East Sussex	61	23

Staff and partner stakeholders (hereafter partners) interviewed for the review all agreed that, in common with other local authorities in England, a decline in demand for Support and Safeguarding Services (SASS) for a lengthy period during Covid restrictions had been gradually reversing, with referrals 'really picking up' from around mid-2022 i.e. after the official statistics were last published. Staff and partners also identified recent:

- **Factors with the potential to increase demand** - such as child and family needs affected by the Pandemic (as explored below), partner agency resources reported to have become 'stretched', and partner agencies becoming more consistently informed about (the impact of) and more consistently recording safeguarding concerns.
- **Factors with the potential to reduce demand** - such as continuing reductions in the rate of re-referrals to Social Care Services (attributed to successful interventions at Support and Safeguarding levels), schools becoming more accepting of 'step downs' from Safeguarding or Support levels, and improvements overall in partnership working.

[3] As judged by Ofsted

2.2 Review findings relating to recent trends in the nature of demand

Child Age: Although council staff and partners perceived a post-Covid increase in infants[4] with safeguarding concerns, the data about children with a Child Protection Plan for the last financial year 2022-2023 suggests that the proportion of infants has remained relatively stable at around 14-19%.

Figure 1: Children with a Child Protection Plan April 2022 to March 2023

Age	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Unborn	16	19	18	17	16	16	19	17	13	13	9	14
Under 1	32	29	32	32	39	40	35	39	42	43	42	35
1 - 4	76	73	80	83	84	81	81	65	58	58	63	54
5 - 9	104	86	85	69	73	71	78	73	68	75	74	75
10	23	24	25	21	20	20	20	19	15	13	11	12
11	16	17	19	20	23	20	18	18	20	22	25	22
12	12	8	12	11	11	13	11	14	11	15	15	13
13	11	11	12	13	14	12	11	12	12	12	14	15
14	14	11	13	13	11	12	12	11	13	15	13	13
15	16	16	11	12	14	13	12	14	15	15	17	18
16 +	12	11	16	15	16	15	19	19	18	15	19	16

Post-Covid, staff and partners were also noticing older children and adolescents with mental ill-health having a detrimental effect on child (non) attendance at school, anti-social behaviour and whole family functioning.

Child Disability: The review of safeguarding decision making identified 14% of the 80 children in the sample as having a diagnosed disability, mostly Autistic Spectrum Disorder (ASD) or Attention Deficit and Hyperactivity Disorder (ADHD). Within the broader child journeys sample, incorporating targeted early help (Support) cases, the proportion was slightly higher at 21%. The Front Door review found that approximately one third of contacts were concerned with parent worries about 'child behaviour' mainly linked with (sometimes undiagnosed) ASD or ADHD. Staff consistently described how children with a diagnosis of or suspected ASD or ADHD were presenting more frequently to both Support and Safeguarding services.

Whole family needs: In common with other parts of the country, staff and partners considered that the following child and family needs were very frequently presenting and/or presenting increasingly, at both Support and Safeguarding levels:

- **Domestic abuse including coercive control** (and often allied parent substance misuse issues) – thought by almost all staff and partners to have increased in prevalence during and since the Covid Pandemic.

[4] i.e. children aged under 1 year

- **Child and parent mental health problems** - thought also to have worsened as a result of the Pandemic. Levels of mental health problems amongst referred families were described by some stakeholders as 'overwhelming'.
- **Poverty-related issues** resulting from post-Covid austerity.

Figure 2 below reinforces many of these staff perceptions including a sizeable post-Covid rise in child and parent mental health and learning disability concerns within the context of single assessments.

Figure 2: Single Assessment Factors (Mental Health and Learning Disability) in 2021-2022 - 2023 compared with 2017-2018

	Single Assessments Apr 22 – Mar 23			Single Assessments Apr 21 – Mar 22			CiN data 2017/18
Factor(s) identified (year to date): Multiple factors can be identified by the social worker	**Number**	**%**		**Number**	**%**		
Mental health: child	819	25.6%	79.0%	733	22.1%	73.0%	62%
Mental health: parent/carer	1493	46.7%		1561	47.1%		
Mental health: another person in the family/household	216	6.8%		127	3.8%		
Learning disability: child	566	17.7%	24.5%	531	16.0%	21.8%	19.10%
Learning disability: parent/carer	164	5.1%		160	4.8%		
Learning disability: another person in the family/household	55	1.7%		31	0.9%		

3 Findings regarding thresholds and families getting 'the right help at the right time'

3.1 Awareness of thresholds relating to different levels of need and safeguarding

All staff and most partners participating in an interview were aware or very aware of the Wiltshire threshold documentation and described how they and their colleagues had received training on it. Some described how they used the documentation (including the 'BRAG ratings') actively in seeking to understand when referrals to the Front Door and/or the Multi-Agency Safeguarding Hub (MASH) were required.

Partners mostly considered that thresholds were clear or very clear, particularly for safeguarding. As is often the case, thresholds for lower-level interventions were considered to be a little 'greyer'.

3.2 Threshold and decision making at the Integrated Front Door

At Autumn 2022, Wiltshire's administrative and performance data suggested that:

- **A growing proportion of contacts were being converted** to Early Support Assessments (ESAs). Referrals to the Council's targeted early help 'Support' services had remained at about the same levels and referrals to Children's Social Care had declined slightly. Between 2020/21 and 2021/22, there had been an growth in the proportion of all contacts converted to either an ESA, or a Support and Safeguarding referral i.e. up from 38.5% in 2020-2021 to 46.5% in 2021-2022.
- **The rate of Section 47 child protection investigations and children requiring a Child Protection Plan** was on a par with many comparator authorities. Wiltshire's rate of children with a Child Protection Plan at March 2022 (30 per 10,000) was slightly higher than similar[5] outstanding local authorities, for example Essex (20) and Hertfordshire (19) and around the same as others for example Hampshire (36), Cornwall (37), North Yorkshire (36.5) and Kent at (36) per 10,000 population.

3.2.1 Fourteen Key Findings from IPC's Front Door Review

1. Services working with children and families were overall 'referring' the right children and families into the Integrated Front Door.
2. Having an integrated Front Door meant that there was an appropriate breadth to what was received as a contact and subsequently triaged using the 'BRAGing' system.
3. There was a confidence amongst people working within the Front Door that partners understood the threshold criteria and the partner interviews reinforced this finding. MASH 'roadshows' and other regular workshops were helping to explain referral processes and thresholds on a rolling basis,
4. The content of contacts received from partner agencies was mostly good, although more attention could be paid by partners to ensuring consistently high standards for example in relation to informing parents about the referral.
5. The service drew effectively on information from earlier referrals and history as well as more immediate information to consider how best to meet child and family needs.
6. 100% contacts were dealt with in a timely way (97% within set targets) and the response to out of hours referrals was also very good.
7. Follow ups to contacts was good, with sensitive conversations held with parents in almost all cases where this was appropriate and possible. Other agencies' information was also sought, with good use of Police and Health colleagues in the MASH to access their information systems.
8. IPC reviewers agreed with almost 100% Front Door rag ratings[6] and/or progressions i.e. for advice and signposting; Early Support Assessment (ESA); Support Assessment; Single Assessment (Section 17); and Child Protection Enquiry (Section 47).
9. Thresholds for different levels of response were applied consistently.
10. All contacts were reviewed by the Assistant Team Managers and there was active dialogue about thresholds between partners in the MASH. Overall, management oversight was strong including regular staff supervision. Multi-agency oversight and governance had recently been reinforced by the development of a MASH Strategic Board.
11. In a small proportion of cases where the outcome was not to progress to a formal assessment and planning stage, families were consistently given advice and

[5] Similar geographically
[6] Case file sampling misses the nuances in some cases and there is also always a degree of subjectivity in retrospective ratings

signposting to other services or communication was made with other agencies, as appropriate.

12. The quality of the Professional Outcome Notification Forms (PONF) was a little mixed, with many excellent examples and some that were more limited, where reviewers thought they could be improved to provide even clearer information back to referrers.
13. In most cases involving onward ESA referrals, reviewers were confident that the ESA would be likely to happen, as other professionals were already engaged with the family. However, in a small number of cases, it was difficult to be so confident, as there was limited communication with the agency supposed to lead the ESA, for example the school.
14. Schools appeared to be more enthusiastic about taking the lead for an ESA where the issue(s) were obviously focused on the child's behaviour in school and less enthusiastic where the issue(s) were predominantly community, whole family or adult-focused.

3.2.2 Front Door-related findings from other aspects of the overall review

From case file sampling: Approximately one third of the children receiving a form of local authority plan examined by reviewers as part of the review of child journeys had been referred by schools. Linked perhaps with the ESA findings, these children were more likely to receive a Support Plan compared with children referred by other agencies such as the Police or community health services.

Children referred to Support had already received an earlier ESA in approximately one third of cases, and these were mostly school-led ESAs. In these instances, either the parents had not engaged with the ESA or the family circumstances had become more complex whilst the ESA was in place or commencing.

Where children were referred into Support Services, reviewers agreed that this was the right level of planning and support for the child, although in, a small number of cases, it would have been equally valid for the child to have been referred for Child in Need or ESA support instead, demonstrating how finely balanced these decisions can be.

From partner interviews: A strong majority of partners were confident or very confident about the MASH and thought that it was functioning well or very well as a multi-disciplinary team. Partners noticed that some elements that had been improved and/or particularly valued, for example:

- That they could get speedy, excellent advice and 'consultation' support from the Front Door, including from the Early Intervention Advisors.
- That a culture of challenge had been promoted within the Front Door as well as across the SASS to ensure partners were able to challenge referral decisions.
- There had been improvements in documenting decisions (including through the PONF documentation).
- Safeguarding 'link roles' had been created between SASS and other organisations.

Overall, partners agreed with the findings of this review that children and families were consistently being directed into 'the right help at the right time' by the Front Door.

3.3 Decision making beyond the Front Door

A strong theme from the interviews was that partners felt involved as equal partners in Support and Safeguarding decision making, and 'listened to'. Similarly, partners described feeling able to challenge decisions, and that these challenges were consistently taken seriously.

Support and Safeguarding staff noticed how features of the current system to triage children and families into the right help at the right time from the Front Door onwards were working well, supported by effective, flexible decision making throughout a child's journey. They consistently described how, even where referrals from the Front Door / MASH on occasion did not immediately 'land' at the right level, this could be rectified speedily because the structure of the overall SASS supported this smooth transition. Other positive aspects of confidence included that:

- Staff very consistently described being very able to challenge early or subsequent decision making about the level at which the case should be worked, including at any stage of the child's journey.
- Everyone working in the whole system considered that having very stable teams of experienced family key workers (and effective management of these teams) integrated with locality social work teams enabled confidence that safeguarding issues would be detected and children and families could be stepped up to Safeguarding Services where appropriate.
- The threshold guidance was described as being applied in a very consistent way by team managers.

Staff considered that most partners contributed well to a range of important multi-agency meetings such as strategy discussions and child protection case conferences. Participation was considered by some to have been aided by post-Covid changes such as a shift to using 'Teams' or hybrid meetings.

3.3.1 The quality of assessments underpinning decision making beyond the Front Door

The review of safeguarding-specific decision making in a sample of 80 case files identified consistently high-quality decision making supported by consistently high-quality social work assessments.

Key attributes of assessments underpinning safeguarding decision making were that they were sensitively undertaken, strengths and risks recognised and analysed carefully, written for the child, made good use of the history / chronologies and tailored assessment tools (mostly Circles of Safety or the Pre-birth Protocol, also the Graded Care Profile) and proposed clear action plans. Outstanding assessments were characterised by:

- The reader being able to 'really hear' children's and parents' voices.
- A clear outline of other agencies' perspectives of the family's strengths and risks.
- A very clear chronology.
- High quality analysis.
- Research / the evidence base referenced, where appropriate.

The quality of some assessments was affected negatively, in a small proportion of cases, by parental non-engagement in the assessment process. This meant, for example, that parental voice and a more in-depth understanding the family's needs could not be gathered.

The review of whole child journeys (across all levels of SASS) similarly found that the quality of decision making for children was consistently underpinned by high quality assessments. Key attributes of these assessments included that they were:

- Holistic and involved all key family members (including fathers as well as mothers and extended family members, representing their views).
- Focused on the needs of the child and clearly represented their voice – sometimes addressed directly to them.
- Inclusive of a range of professional perspectives.
- Able to clearly reference both strengths and risks and made good use of specific tools[7].
- Incorporated clear analysis and decision making.
- Inclusive of creative strengths-based family solutions.

Staff at all levels expressed high levels of confidence in their assessment practice and could reference tools and guidance they utilised to help complete assessments at different levels.

3.3.2 Decision making (about the level of support for a child)

There was considerable evidence from case file sampling that Wiltshire's system regularly flexes to meet the needs of children, including to 'step up' to Child Protection or 'step down' to Child in Need, Support or ESA as appropriate. For example, 35% children starting their journey through services as a Child in Need were stepped up relatively quickly to Child Protection level because the risks escalated, and 20% were stepped down relatively quickly to 'Support' or ESA. 45% of the children and families in this sample received a measurable package of support exclusively under a Child in Need Plan.

3.3.3 Child protection decision making

Safeguarding strategy meetings were very well attended by the relevant agencies and the decision making at this stage was considered appropriate in 100% case files examined. There was also evidence of high-quality triage and warm handovers into appropriate pathways (e.g. Child in Need planning, Support services, or other forms of support) in almost all cases.

Partners interviewed for the review understood the need to be involved in case conferences and core group meetings, and some thought online meetings had assisted with attendance levels. The main reason given for not being able to or releasing staff to attend all statutory decision-making meetings in recent times was staffing shortages. Some partners described how this meant they had occasionally prioritised some (child protection conference) meetings over other types.

[7] Such as the Graded Care Profile (Home Conditions); an Alcohol Audit, a Scaling Tool for risks; 'MOMO' or 'Getting to know you' tools to surface the voice of the child.

The process of pre-meeting 'scoring' of risks was considered by partners to assist greatly in enabling independence of voice for each conference member (this was also evidenced in case file sampling – see below). One area for continuous improvement in child protection decision making suggested by partners was to encourage and support even more children to attend statutory meetings about them. This review did not support an in-depth exploration of children's attendance at decision making meetings. However, reviewers did notice that family members and, in some cases, children of the family were regularly attending these meetings. We also understand that this is an aera that has started to be more closely monitored in Wiltshire through the case management system.

Partners who had a view about the quality of case conferences described the facilitation and operation of these meetings very positively.

The case file sampling elements of the review also demonstrated how child protection case conferences were well attended by relevant partner agencies in approximately two thirds of initial conferences. In approximately one third of cases, there were some gaps but, in all cases, key partners did send a report where they could not attend. There was good use made by all partner attendees of the 'risk scales' and pre-conference reports which, combined with the healthy debate evidenced within meetings and conference chairs exerting their independence in some instances, was suggestive of good quality information sharing and challenge. There was also evidence of comprehensive post-conference planning involving a wide range of services, particularly:

- Family Group Conferencing (in 50% cases).
- Circles of Safety Planning (in 70% cases).
- Support for parent mental health (in 45% cases).
- Support for domestic abuse from specialist partners (in 40% cases).

Other frequently included services were CAMHS, substance misuse services, and Dads Matter Too (for fathers).

Child Protection Plans ranged in length from 2 to 29 months. The mean (average) length was 11 months, and the mode (most common) length was 3 months.

At a final Child Protection Case Conference, attendance by key partners was less evident in the case files sampled. In approximately two thirds of cases, there were one or two significant absences, notably from community health services. Reviewers considered this to be a gap, given the often ongoing health needs of children involved. Schools, School Nursing and Family Nurse Partnership (FNP) were more regular attendees. Levels of participation were very low in approximately one third of cases, (e.g. only the social worker and one or two other attendees). In these instances, it is important to note that most key contributors to decision making did send a report (including risk scoring) in advance of the meeting, to enable relatively effective decision making.

Reviewers agreed with the decision making in all Child Protection Case Conference cases examined. Most children who stepped down from a Child Protection Plan did so into a Child in Need Plan to ensure continuity of support.

3.4 Broader partnership support for decision making beyond the Front Door

Stakeholders consistently described multi-agency working in Wiltshire in positive or very positive terms, including with reference to day-to-day communications, multi-agency fora, safeguarding-focused training or meetings and annual safeguarding assessments.

Many staff interviewed for this review also had very positive things to say about working with partner agencies in Wiltshire. Resources from a range of partner agencies (not just commissioned services) were sometimes described as 'stretched' but staff from Support and Safeguarding teams worked creatively with partners to achieve joint plans. Making time to communicate well with partners was seen by SASS staff as an essential part of their role.

SASS staff often described good or very good relationships with schools in their locality. Being able to sustain effective communications with the schools was considered to be of utmost importance, including through 'link workers' matched with individual schools. However, some staff described how schools could rely a little too heavily on the Support and Safeguarding Services (rather than making their own early or earlier help in some instances). This was sometimes attributed to schools having lost funding for their Parent Support Advisors (PSAs).

Partnership working with Health, particularly midwifery and health visiting, was also consistently described in positive or very positive terms by SASS staff. Relationships, trust, and good working practice had been established it seems in all areas. Again, having a link worker within these services was identified as being very helpful.

Partnership working with the Police (outside of the MASH) and Army Welfare Services was described in more mixed terms by staff and partners, with inconsistency being the most frequent descriptor in terms of information sharing and contributions to joint investigations. However, more recent improvements in work with the Police were also noted.

Work with the two key commissioned services: Turning Point (for substance misusing parents) and Splitz, now 'Fearless', (for domestic abuse supports) was thought to be generally effective, particularly where 'link workers' from these 2 services had been assigned to SASS locality teams. However, increases in demand for these services during and post-Covid had placed additional pressures on the services and some interviewees would like resource allocations to be reviewed. Family Group Conferencing and innovations in local authority supports, for example Dads Matter Too (for fathers) were also considered to be making a very positive difference to children and families.

Staff and service leaders across the Council and partner organisations consistently described how they would like further opportunities to secure support for children and families to be explored in the following 3 areas of need:

- **Adult mental health / emotional wellbeing supports** - particularly for parents and carers with a level of need that is 'higher than for IAPT'.
- **Child emotional health and wellbeing.** Specialist Child and Adolescent Mental Health Services (CAMHS) were considered to have ongoing very high thresholds and long waiting lists. CAMHS was often described as 'the most challenging' service to try to get involved. However, some staff did mention being able to access a

CAMHS 'consultation worker'. Some also talked about schools 'taking on the Thrive Approach to fill the gap'. However, many partners could still see children falling between the gaps between universal and specialist child emotional health and wellbeing services.

- **Support for children with (suspected) ASD or ADHD** was also often described as a significant gap. SEND services were described by some interviewees as being 'overwhelmed' and therefore at times 'closed to referrals'. The burden of work with these children and their families could fall often or sometimes on family key workers who, whilst very competent in more generic family support practice, might lack the specialist training to offer very tailored advice and support. An alternative view was that children with less complex SEND needs locally had more options than before, such as positive activities and a 'good offer' of parenting courses. A major issue was considered to the (timely) diagnosis enabling provision of tailored support for ADHD/ASD. Some stakeholders thought there should be a specialist service for children with neurodiversity.

4 Findings regarding the quality and effectiveness of Support and Safeguarding Services

At Autumn 2022, Wiltshire's performance data suggested that there were:

- **Low rates of children needing to be re-referred to Support and Safeguarding Services** within 12 months of a statutory Child in Need or Child Protection Plan ending (approximately 16%). This is very good performance. The range amongst statistical neighbours in 2021-22 was 15% to 34% with an average of 23%. The range amongst demographically similar outstanding local authorities[8] was 14% to 28%, with Wiltshire's rates most like those of Hertfordshire (14%), North Yorkshire (16%) and East Sussex (16%).
- **A good and improving proportion of assessments** (approximately 85-90% in 2021-22) **and Child Protection Conferences** (approximately 93% in 2021-22) being **undertaken within target timescales**. These are higher (i.e. better) rates than statistical neighbours (at just over 80%).
- **A relatively low rate of children needing to become looked after** (declining steadily since 2018 including during Covid, particularly amongst children aged 16+). At 2021-22, the rate per 10,000 population was 14 which, whilst at the lower end compared with statistical neighbours, was very similar to many authorities judged by Ofsted to be outstanding.
- **Good rates of permanent social workers in post** (84%) and caseloads (average 20 children per social worker[9])

Partners with direct experience working with SASS had a positive or very positive view of the service overall, including that assessment and other practice had developed and improved over recent years including to become even more consistently:

- Relationship-based.
- Trauma-informed.

[8] North Yorkshire, Hertfordshire, East Sussex, Suffolk, Kent, Hampshire, Cornwall and Essex
[9] With an aspiration to continue to improve these rates i.e. to increase permanent social workers in post and reduce (to around 16-18) the caseloads of social workers – when full staffing is achieved

- Solutions-focused and non-judgemental.
- Open and honest with families.
- Holistic i.e. focusing on the child's safety but also engaging with parents, including both mothers and fathers.

Partners recognised the considerable skills and positive attitudes of both social workers and family support workers and the advantages of such a mixed overall team.

> "Family Key Workers have made a big difference but we still haven't got enough of them. They are brilliant and have integrated well, they deserve a medal"

4.1 The quality of practice from social worker and family key worker perspectives

A very common theme from staff interviews was that Wiltshire's SASS practice had strong theoretical underpinnings (attachment, transactional analysis, trauma-informed practice) and was supported by a range of tools workers were encouraged to use flexibly. Practitioners at all levels described being confident (sometimes very confident) about the quality of their practice and described it as relationship-based, systemic, trauma-informed, focused on (writing to) the child and on solutions. Whereas family key workers described working with a range of family members, many social workers referenced engagement with children as being the most important element of the direct work they undertook, including to hear, represent and respond to the child's voice.

A strong theme was that social workers and family key workers were confident to engage with family members on Support or Safeguarding assessments and plans.

4.1.1 The quality and impact of support level plans and services

Social workers and managers interviewed for this review had a very high level of confidence in the ability of family key workers to undertake pieces of direct work with families as part of Support or Safeguarding plans. They also described the positive benefits and high quality of joint work that could happen (between family key workers and social workers) on some statutory cases.

In all Support service cases examined for the review of child journeys, the main allocated worker was a family key worker.

There was very strong evidence of effective family key worker engagement of children and family members in the support offer. Consistently evidenced qualities of the early engagement work with families included that it was:

- **Non-judgemental** and **strengths-based**, for example focusing on exploring the positives including what families did already to support each other and to support family members to find their own solutions.
- **Involving of the whole family i.e**. not just mothers, but also fathers where at all possible, also all the children (not just the 'key' child) and other family members, as appropriate. Often, the family key worker met with family members both individually and together, offering opportunities for them to voice their own experience.
- **Characterised by active listening**, including encouraging members of the family to share experiences.

- **Persistent where appropriate** including relying on several methods for reaching families e.g. texts, telephone calls, turning up at the home, working through other professionals already known to the family.

Other qualities included that family key workers offered: early reassurances about their role (and how it was different to social work); time for family members to build a relationship; flexibility e.g. around timings of or venues for sessional work; creativity e.g. 'walking and talking' rather than sitting and talking; early practical help, where appropriate; tools to explore family dynamics and their motivation to change; sensitivity to parental concerns e.g. that a history of social care involvement will continue.

One or both parents chose not to engage with the family key worker in a very small proportion (10%) of cases. In almost all cases, this seemed like a reasonable outcome, as the family wanted, and from all the evidence could rely on existing professional and/or family-based support in the community. In other words, these were not instances of higher risk families disengaging.

The Support plans for children and families led by family key workers were in all cases comprehensive and included a wide variety of:

- Family key worker-led activities.
- Referrals or warm hand offs to other services or professionals.

Family key worker-led activities most frequently included: (1) work with one or both parents to support parenting understanding and confidence, routines, boundary setting and strategies – often based around 5 to Thrive for younger children and STOP parenting work for older children; (2) safety work including (circles of) safety planning with the adult and child members of the family and 'Freedom Programme' work 1:1; (3) direct emotional health and wellbeing support for the child(ren) including work on identity, self-esteem, anger, exploitation risks and school attendance (coaching); (4) work on healthy relationships with one or multiple members of the family e.g. with a couple to support their understanding of triggers for arguing / abuse, effective communication strategies and conflict resolution; (5) identification, encouragement and role modelling of positive (physical) activities in the community.

Family key workers' direct practice was frequently informed by specific programmes and models (e.g. Circles of Safety, Freedom Programme, 5 to Thrive). Reviewers also noted trauma-informed practice in a number of cases. Commonly used tools to support practice included: MOMO (Mind of My Own); 3 Houses; visual feeding / routines diaries and charts; 'My Emotions' worksheets; Volcano in My Tummy; online safety tools; Therapeutic Treasure Chest and others.

Referrals / warm hand offs were frequently made to (1) CAMHS, including not only for assessment but often for consultation; (2) Adult Mental Health Services, mostly IAPT; (3) Splitz, including for work with all members of the family, as appropriate; (4) Healthy Eating Services e.g. dietician; (5) Paediatrician services e.g. for ADHD or ASD assessments; (6) Barnardo's Child Emotional Health and Wellbeing Services. However, a much fuller range of services could clearly be accessed for children and families including: young carers; housing support; employment support; Motive 8 (substance misuse service for young people); perinatal mental health; children's centre services; OT assessment; CiL Buddy Services (to combat parental isolation); bereavement

support; adult substance misuse services and more. Plans also often continued to note the importance of ongoing school-based supports such as ELSA or school nurse support.

Referrals to children's services 'innovation' projects were mainly to Emerald and Stronger Families.

Consistency of support worker: In most (82%) Support cases examined, there was one family key worker engaged with the family for the whole period of the Support Plan. In 18% cases, there was more than one family key worker i.e. the key worker needed to change. In just over one half of cases stepped up from Support to Statutory Plans the family key worker remained involved with the family.

Effectiveness of Support Plans: Services and support activities outlined in Support plans were activated, as planned, in almost all cases. However, non-engagement of parents occasionally affected their implementation, also sometimes partner or commissioned services not being available in the desired timescales. There was some evidence that EHCP processes were sometimes delayed, affecting the overall Support Plan.

In approximately one half of Support cases examined, case file sampling suggests that the child and family responded well or very well to the support on offer and progress was made. This is a very good level of response with reference to the level of presenting needs. There were no step ups or further referrals into the Front Door. Key areas of progress included:

- Family relationships and communications.
- School attendance and getting on at school.
- Calm(er) home environment.
- Keeping children safe, including from psychological harm resulting from domestic abuse.
- Parent emotionally stronger.
- Parenting confidence and becoming more proactive.
- Child emotional wellbeing.

In one quarter cases, although there were small improvements for the child and family, the case still needed to be stepped up to children's social care, for example because needs or risks had increased.

In one quarter cases, the family either never really engaged or, as a result of the family key worker being able to understand the family better and uncovering more risk than at referral, a decision was made that the child and family needed to step up to children's social care.

4.2 The quality and impact of child in Need Plans and support

An allocated social worker led the plan in all Child in Need cases examined for the child journeys review.

The quality of engagement with children and families post-referral was high overall with key qualities including:

- Working with and through workers already known to the family e.g. Pause worker or family key worker.
- Open and honest about the concerns, sensitively explained.
- Involving all family members, also extended family where appropriate.
- Non-judgemental.
- Solutions-focused.
- Listening, including encouragement of reflective conversations.
- Practical support offered early, where appropriate, or worker modelling of positive parenting.

Approximately one third (35%) cases were co-worked by the social worker and a family key worker and there was evidence that the family key worker support was sometimes more acceptable to family members, as non-statutory.

Consistency of worker: The same social worker remained involved with the child and family throughout an intervention period (including where cases were stepped up to child protection) in 50% of Child in Need cases examined for the whole child journey review. In almost all instances in the other 50% cases, two social workers were involved, this for valid reasons as they often changed at 'step up' to Child Protection, where a (student) social worker left, or where parents requested a different worker.

Social worker practice: In approximately 50% cases, in addition to their assessment work, the social worker undertook mostly monitoring and coordination work to advance the aims of the agreed plan. In these cases, other workers including family key workers undertook much of the direct work with family members. In approximately 50% cases, the social worker also undertook a proportion of the direct work, mostly with the child(ren) of the family. In some instances, reviewers noted that it would have been very difficult to undertake structured, sessional work with family members as the case was escalated very quickly to Child Protection.

In approximately one third of the Child in Need cases examined, families had access to at least one of the Council's innovation services i.e. Born into Care, Emerald, Stronger Families, Dads Matter Too, or Lighthouse. Families engaged well with all these services. Other specialist supports accessed in Child in Need plans included predominantly Fearless for domestic abuse (involved in approximately one half of cases) and Turning Point for substance misuse (in approximately one third of cases). Referrals were also frequently made for CAMHS (in one quarter of cases) and parent mental health services (in one quarter of cases). Other services included: Family Nurse Partnership, YOT, SEND or ADHD services, Army Welfare Services, Educational Psychology and Housing. However, in some cases, one or more supports were not actually available or did not materialise, largely due to waiting lists. The two most frequently non-available supports were substance misuse services and supports / resources to implement EHCPs. Other less available supports were CAMHS; play therapy for children or perpetrator work via SPLITZ, Stronger Families (during the summer months); and parent mental health services.

Impact of Child in Need Plans: In just over one half of Child in Need cases, there was evidence of a positive or very positive outcome from the statutory journey for the child, and the case was either closed or stepped down to targeted early help services with no

further referrals to MASH. It is very positive to note that a number of these cases concerned infants.

In approximately one quarter cases, the family had made some progress in some but not all areas.

In approximately one quarter cases, the outcomes were appropriate but again less positive in that the child had either needed to become looked after (as concerns so great) or went on to become subject of a Child Protection Plan with ongoing concerns.

4.3 The quality and impact of Child Protection plans and support

An allocated social worker led the Child Protection Plan and intervention in every case examined as part of the review of child journeys. The quality of engagement of the social worker with the child and family was consistently high including:

- Open and honest communication, taking time to explain the concerns and processes.
- Ensuring that children were engaged in talking about their experiences, on their own and sometimes at school.
- Non-judgemental, encouraging parents to talk – listening.
- Involving both mothers and fathers, where possible.
- Strengths-based and solutions-focused.
- Recognising barriers or limitations to parent openness.
- Engaging with the extended family, as appropriate including often grandparents.

Families consistently engaged well at the start of the intervention.

In one half of cases, the family was co-worked with a family key worker, sometimes already known to the family. In one case, the family was co-worked with a social work student. The role taken by family key workers was varied and included: structured parenting sessions; work with parents on healthy relationships; direct work with the children e.g. on keeping safe; or work on home conditions and routines. The roles appeared to be clearly defined (between the social worker and family key worker) and the work well-coordinated.

Consistency of Worker: The same social worker was involved with the child and family throughout their journey in one quarter child protection cases examined for the review. In approximately one half of cases, 2 social workers were involved with the family through their journey. However, in these cases, reviewers often noted that the same key worker was involved (where relevant) throughout the whole period, creating consistency for families. In approximately one quarter cases, there were between 3 and 4 social workers involved with the child and family throughout their journey. Often, these cases spanned more than one year.

Social worker practice: In approximately one half of cases, there was evidence of direct work being undertaken regularly by the social worker with either with the child or parent(s). In one half of cases, the social worker had focused more on assessment, statutory visits and court work. In these cases, a decision had been made that it was better for family key workers to lead the direct work with family members. There was

some evidence from case file sampling that family members preferred to engage with a family key worker to undertake many aspects of the direct work.

Council innovations were involved in some Child Protection cases, including Dads Matter Too, Lighthouse, and Stronger Families. Other specialist services engaged in providing support for Child Protection plans included mostly substance misuse services e.g. Turning Point; parent mental health support e.g. through IAPT; and domestic abuse supports e.g. through SPLITZ. Services involved less frequently included: CAMHS, Motive8; adult social care (LD); Family Nurse Partnership; Family Group Conferencing and a Child and Parent Residential Placement. Fathers were clearly encouraged to access supports as well as mothers.

Key gaps in the ability of services to meet child and family needs articulated in the plans appeared to be for:

- **Child emotional or mental health** – in approximately one quarter of Child Protection cases, reviewers identified gaps in statutory services (e.g. CAMHS not accepting referrals) or voluntary services (e.g. services having long waiting lists) and, in some instances, social workers not even seeking this type of help for the child, presumably because they did not believe it would be forthcoming.
- **Assessments for ASD/ADHD** – in approximately one quarter of Child Protection cases, reviewers identified that these assessments were slow to progress even over several statutory plans.
- **Face to face specialist domestic abuse work** – at times offered only online by SPLITZ.

Other key limitations of Child Protection plans resulted from parental (lack of) motivation to utilise some aspects of the support being offered. This happened in approximately one half of Child Protection cases and typically involved fathers not engaging in substance misuse supports or mothers not engaging or engaging only sporadically in domestic abuse or mental health supports.

Impact of Child Protection Plans. The children and families subject of a Child Protection Plan in this review cohort had largely very positive outcomes.

In a very high proportion (approximately three quarters) cases, the child(ren) remained living with their parent(s) and improvements, sometimes very significant improvements, were noticed in their care and wellbeing by the social worker and broader team around the child. In most cases, the child and family were stepped down to a Child in Need Plan for a period before case closure, and in no instances did reviewers notice a subsequent re-referral(s) post-closure. Some of these cases involved extended family members stepping in to support the child and parent(s) for periods of time.

In a small number of cases, the child(ren) became looked after by extended family members or foster carers. However, in many of these instances, parental contact was being actively maintained.

5 Findings regarding supports for effective practice

Partners interviewed for this review described in very positive terms how Support and Safeguarding Services were being managed and the ways in which they interacted with the whole system for children and families in Wiltshire, including in comparison to other local authorities.

> "There are lots of people doing great work, I can't praise social workers enough for the work they do. Overall it is generally positive and professional and we share the same goals and outcomes"

Overall support for team members within localities was consistently described by SASS staff in good or excellent terms. Words frequently used to describe the qualities of support for the job included: safe, supportive, positive, managed, approachable, flexible, accessible, and listen(ing).

Staff consistently described being part of a Support and Safeguarding Team as rewarding and enjoyable.

Supervision arrangements: There were also consistently positive messages from staff about the quality of formal supervision arrangements in the locality teams (both 1:1 and group-based or peer supervision). Staff appreciated the focus on both the management of caseloads and their personal wellbeing. However, there was a minority view that receiving support from multiple ATMs could lead to inconsistencies at times and staff had to adapt to their different approaches. Similarly, some staff felt that ATMs or Team Managers who were new(er) in role sometimes left them less supported as they 'got up to speed'. Staff morale was generally high and had dipped only a little in some localities where they had been under-staffed for a time.

Team managers appreciated the support from service and more senior managers although reflected that it could at times be 'lonely in the role'.

Training: Not all staff commented on the training supports in place in Wiltshire. Of those that did, comments were consistently positive, including that there were lots of opportunities to train and that this time was valued in the authority.

Other supports: Interviewees also mentioned a large range of 'other supports' they considered to be helpful or very helpful to them and their work, including group pod meetings; having meals together as a team; focused training as a group; role-specific 'support groups'; ASYE manager; mentoring / buddy arrangements; IT support (Liquidlogic).

Several workers also mentioned how well Wiltshire supported staff experiencing trauma or its after-effects, including through the therapeutic 'TRIM' service.

6 Summary findings and recommendations for future development

This comprehensive review provides well-triangulated findings and evidence for:

1. Positive post-Covid re-growth in demand for all aspects of Support and Safeguarding Services in Wiltshire.

2. Children and families consistently getting the right help at the right time throughout a journey into and across a well embedded Support and Safeguarding Service, including as a result of:

- High levels of whole partnership understanding of thresholds.
- The effectiveness of Front Door arrangements in which all partners can have confidence.
- High quality, holistic assessments undertaken at all levels that really listen to the child's voice.
- Regular and robust decision making supported by partners at most stages of the child's journey.
- Staff and partners feeling able to challenge decisions at all levels and throughout the child's journey.
- An overall system predicated on the assumption that children's needs change or reveal themselves differently post-referral and therefore enabling safe and easy 'step ups' and 'step downs' – a 'one plan' approach.
- A good range of support services working closely with family key workers or social workers who are leading plans and including Council-led innovations as well as those tailored to the needs of SASS families and provided by external partners.
- Services being underpinned by a stable, experienced and committed group of managers.

With reference to key performance trends including for looked after children and re-referral rates, Wiltshire is now on a par with most other local authority services judged by Ofsted to be outstanding.

3. The robustness and effectiveness of Support and Safeguarding practice that consistently demonstrates very positive attributes including: relationship-based; trauma-informed; strengths-based and solutions-focused; holistic (including fathers as well as mothers, also broader family members).

The review has demonstrated the real strengths of Support and Safeguarding teams working alongside each other in localities, including to provide consistency of support for many families stepping up to or down from statutory plans. Confidence in practice was consistently high amongst family key workers, social workers and partners. There was also evidence of very good supports for practice including through: excellent supervision arrangements, good quality training and development, broader team-based care and support; and specific supports such as the highly regarded 'TRIM' service for staff experiencing trauma or its after-effects.

The review also suggests ways in which the Support and Safeguarding Service and wider partnership arrangements could achieve even greater excellence including by:

1. Working to improve partner attendance levels at some, particularly concluding Child Protection Conferences.
2. Continuing to encourage attendance by children at their child protection meetings.
3. Improving the timeliness of information for services into which children and families are being referred for an ESA or ‘stepped down’ at the end of Support or Safeguarding Plans.
4. Reviewing the availability and flexibility of key supports for children with a statutory plan i.e. from domestic abuse and substance misuse services. We agree with senior managers that it is worth considering the extension of existing multi-disciplinary team working to include domestic abuse and substance misuse workers even more embedded in all locality teams.
5. Working together to improve access for children and families with a Support or Safeguarding Plan to key areas of support outside of Support and Safeguarding core teams, in particular to support for child and parent/carer mental health and wellbeing, and for children with ASD or ADHD and their parents/carers.

Appendix A: Underpinning reports regarding all aspects of this review

1. A review of the activity and performance data at Autumn 2022

2. A review of the Front Door

3. A review of decision making

4. A review of the whole child journeys into and through Support and Safeguarding

5. Interviews with staff

6. Interviews with stakeholders (partners)