St. Helens Metropolitan Borough 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: 5 November 2014 - 25 November 2014

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The overall judgement is that children's services require improvement
The authority is not yet delivering good protection and help and care for children, young people and families. It is Ofsted's expectation that, as a minimum, all children and young people receive good help, care and protection.[2]

The judgements on areas of the service that contribute to overall effectiveness are:		
1. Children who need help and protection		Requires Improvement
2. Children looked after and achieving permanence		Requires Improvement
	2.1 Adoption performance	Requires Improvement
	2.2 Experiences and progress of care leavers	Requires Improvement
3. Leadership, management and governance		Requires Improvement

[1] Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspection Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

[2] A full description of what the inspection judgements mean can be found at the end of this report.

Contents

The local authority

Summary of findings

Children's services in St. Helens require improvement because:

Help and protection

- Early help services do not support some children soon enough to prevent their situation from getting worse. There is insufficient focus on children in need, and too many children's cases are closed or stepped down to universal services before needs have been fully assessed and sustained improvement assured.
- Too many children are subjected to child protection enquiries when they are not required, and many children wait too long, and have repeat referrals and child protection plans, before a stable, safe outcome is achieved.
- Assessments do not sufficiently consider or analyse historic risk which impacts on the quality of child in need and child protection plans.

Looked after children and care leavers

- Leaders at all levels are not sufficiently ambitious for looked after children and the attainment gap is not closing quickly enough. The achievement of looked after children is poor.
- Not all looked after children benefit from up-to-date assessments and not all children's plans reflect their current needs.
- Adoption is not achieved quickly enough for some children who have waited, and continue to wait, too long before being placed with their adopters.
- Too many care leavers are not in education, employment and training. There is a lack of aspiration and priority afforded to the education of these young people by corporate parents which is impacting on the ability of some children to achieve their full potential.

Leadership and management

- Managers do not have sufficient oversight of case work and do not quality assure assessments or plans robustly enough.
- Domestic violence services for children and their families are underdeveloped.
- The development of the Multi-Agency Safeguarding Hub (MASH) has been slow and has not yet secured the involvement of key partners to improve the quality of information sharing and risk assessment.
- Performance management arrangements do not sufficiently focus on the quality of practice and the outcomes for children and young people.
- Information obtained from interviews when children go missing is not yet informing strategic activity to understand the prevalence of Child Sexual

Exploitation (CSE). Patterns and trends of perpetrator behaviour are not fully understood.

What does the local authority need to improve?

Priority and immediate action

Looked After Children

1. Ensure that the profile, aspirations and educational attainment of looked after children and care leavers are raised by concerted effort from partners and the local authority as corporate parents.

Early Intervention

2. Ensure full implementation of the early help strategy and that all partners undertake common assessments and the role of lead professional for children and families who have emerging vulnerabilities.

Thresholds

3. Ensure that there is a clear understanding and implementation of thresholds across the continuum of need so that children and young people receive the right help at the right time.

4. Review the thresholds applied to child protection enquiries and strategy discussions and ensure that there is appropriate multi-agency information sharing to inform decision making, so that children and families are not unnecessarily subject to child protection investigations.

Missing children

5. Ensure that appropriate systems are in place to gather and analyse information on missing children and children at risk of sexual exploitation, to enable patterns and trends to be identified and used to inform intervention and support for young people at risk, and enable perpetrator disruption.

Assessment and planning

6. Address the outstanding recommendations from the previous inspection to improve the timeliness of children's health assessments and improve the quality of Personal Education Plans (PEPs) for looked after children

7. Ensure that managers are effectively monitoring and influencing the quality of social work practice in assessment and planning.

Areas for improvement

Early help and protection

8. Complete the implementation of the multi-agency safeguarding hub (MASH) to fully support information sharing and evidence-based decision making in child protection work at an early stage.

9. Develop a common risk assessment model for domestic abuse and ensure that child and adult victims have access to targeted support services based on an analysis of local need.

10. Improve the quality of early help, children in need and child protection assessments, and ensure that assessments consider and analyse historical risk factors and address all aspects of need before cases are stepped down.

11. Ensure that children in need plans and child protection plans focus on key risk factors; that they are specific, with clear timescales and measurable outcomes; and that the impact of interventions is closely monitored by managers.

12. Place the experiences of children, as well as their wishes and feelings, at the heart of practice and particularly within recorded assessments and plans.

13. Ensure that the needs of children and young people arising from racial and cultural identity, religion and disability are fully incorporated in assessment, care planning and recording.

Looked after children

14. When there are plans to return a child home, ensure that there is a robust assessment and appropriate support to demonstrate that the plan is safe and the family can sustain change. Ensure that appropriate support is provided.

15. Ensure that all looked after children and children with disabilities in short break provision have an up-to-date care plan which is outcome focused and addresses their current and emerging needs.

16. Improve the timeliness of looked after reviews, and ensure that social workers circulate reports in sufficient time to enable Independent Reviewing Officers (IRO's) to prepare adequately and to enable parents, carers and children to fully participate.

17. Increase the capacity of the fostering service in order to keep pace with the demand for kinship assessments and the recruitment of foster carers, and ensure that all foster carers are offered training and development opportunities to keep their skills up to date and help them care for children more effectively.

Adoption and permanence

18. Reduce the time taken to place children for adoption after a court order is made.

19. Ensure that children benefit from timely life story work to help them understand what is happening to them.

Care leavers

20. Increase the number of care leavers in education, training or employment.

21. Improve care leavers' knowledge about their health, rights and entitlements by ensuring that they have access to up-to-date information.

22. Ensure that all care leavers have an up-to-date pathway plan which is outcome focused, addresses all of their needs and is subject to management review.

Leadership, management and governance

23. Strengthen the performance management framework to focus on quality of services to children as well as compliance to requirements, and ensure that this is underpinned by an improved analysis of performance information.

24. Ensure that audits focus on the quality of social work practice and evaluate the impact of interventions on outcomes for children and young people.

25. Ensure an improved focus on quality and learning from audits and ensure that supervision is reflective and addresses the development and training needs of social workers.

26. Establish and embed a system for monitoring the effectiveness of training provided to the social care workforce.

27. Work with the tri-borough adoption service Warrington, Wigan and St Helens (WWISH) to ensure that it is able to respond effectively to the need to undertake assessments of adopters within government timescales.

The local authority's strengths

28. The workforce strategy (2014–15) and updated supervision policy are of good quality. There is a solid offer of support for newly qualified social workers (NQSW's) and social workers in their first year of qualification (ASYE). A comprehensive training and development plan and access to good quality training supports the recruitment and retention of qualified social workers.

29. There is a consistently strong, constructive and coordinated response to 16- and 17-year-old young people who are vulnerable to homelessness.

30. The Public Law Outline has been used effectively to improve the average duration of care proceedings to 24 weeks, against a national average of 31 weeks.

31. Managers have a very strong understanding of the adoption scorecard. Fostering for adoption placements are actively considered so that children can live with their adopters as soon as possible. Social workers are tenacious in finding adoptive placements for hard to place children and children with complex needs.

32. Adopters are well supported throughout the adoption process and have had the opportunity to participate in the Webster Stratton parenting programme since 2013. Direct work with children and individual therapeutic interventions such as play therapy are provided to adopters together with support for school admissions and any health issues. Placement stability for children is good. There is a wide range of services and bespoke packages to support the emotional well-being of looked after children and care leavers, which means that they receive timely responses to their therapeutic needs.

33. Almost all care leavers remain looked after until they reach 18 years of age. Care leavers benefit from close, supportive relationships with workers who know them well. The local authority is in touch with all of them. The range and standard of accommodation for care leavers is good.

34. Young carers are given a high profile. A commissioned service wraps around children and young people between the ages of six and 18 years of age providing group work, one-to-one support, weekends away and emergency responses. There are clear pathways to children's social care if safeguarding needs are identified.

Progress since the last inspection

35. Safeguarding and looked after children services in St Helens were last inspected in June 2012. That inspection judged the overall effectiveness for both safeguarding and looked after children services to be good, with outcomes for safeguarding judged to be adequate. Action planning in response to that inspection has been methodical although, three recommendations remain outstanding:

    - the local authority is not yet ensuring that all looked after children receive their annual health assessment within statutory timescales
    - the authority has not improved the quality of Personal Education Plans (PEPs) nor improved the quality of pathway plans for care leavers.
    - the authority has not yet ensured that team managers in assessment teams are having sufficient impact on individual cases and social work practice to improve the quality of assessments and care planning.

36. The educational attainment of looked after children and the numbers of care leavers in employment, education and training have deteriorated significantly since the last inspection.

37. The local authority recognises that there is more to do to ensure that the overall effectiveness of service provision achieves better outcomes for children and families. Action has been taken to address poor quality child protection planning in cases of chronic neglect. This resulted in the looked after children population growing from 350 to 412 which is significantly higher than similar authorities.

38. In 2012, St Helens joined with two neighbouring Local Authorities to establish a shared adoption service. In response to poor performance, the casework social workers were relocated back to the authority in April 2014. This is beginning to have a positive impact on outcomes for children and young people.

39. In May 2014 the Local Safeguarding Children's Board (LSCB) launched the refreshed Continuum of Need threshold document. In June 2014 the local authority restructured its early help services, locating the priority families programme alongside the early intervention service. Children's centres were reorganised into two clusters in July 2014, each based on a hub and spoke model. Many service changes have been introduced in recent months and are yet to show significant impact; some are yet to be fully implemented.

40. In June 2013, a revised model for contact, first response and assessment teams was launched. An Assistant Director of Early Help and Protection was appointed. The number of teams and social workers was increased and a dedicated duty function was created. A Multi-Agency Safeguarding Hub (MASH) was developed in January 2014 which co-located the Police Family Crime and Investigation Unit (FCIU) with children's social care, but development of the MASH has not yet included the introduction of other partners.

41. An extensive programme of audits has been undertaken. The authority has engaged in peer challenge summits on self-assessment, data and performance. Findings correlated broadly with inspection findings, although the local authority's most recent self-assessment does not sufficiently identify all required areas for improvement.

42. The co-location of Public Health with children's social care and the recent SEND Reforms has improved coordination of work. So, too, have the reviews of Child Adolescent Mental Health Services (CAMHS) and speech and language therapy services. A social worker from adult services has been allocated to transition planning for children with disabilities to co-work with every young person from their 16th birthday.

43. The social care workforce development team has provided Child Sexual Exploitation (CSE) training to the LSCB and elected members to raise the profile of CSE. To further strengthen their approach; in June 2014 St Helens commissioned Catch 22, an independent provider, to deliver a CSE service to children and their families and also to lead on missing from home and care interviews.

44. In August 2014, the local authority implemented a new Quality Assurance Framework and a review of the safeguarding unit is underway. This new framework is yet to have an impact on improving the consistency and quality of social work practice.

Summary for children and young people

- Services that provide help and protection for children, young people and families in St Helens are being improved to make sure that support is available when it is needed. Many changes have been made recently, some only in the last few months, and it is too early to see what difference they are making. Parents, children and young people, as well as local authority managers and staff, are positive about the changes, but they know that there is more work to do. Those in charge of services recognise that they need to listen more to children, young people and their families to help them make services better.
- Social workers need to give children and young people more help and support to understand what is happening to them and how long it will take. Parents and carers also need to know what they have to do to make things better, who is going to help them and what will happen if things do not improve.
- When children and young people first need help, teachers, health visitors, midwives or family intervention workers will find out what help is needed and provide support, but not all professionals provide this help soon enough. If children and young people need protection, social workers quickly become involved to make children and young people safe, but sometimes children and young people experience a child protection investigation when this is not needed. When support is needed, social workers and managers do not always stay involved with families until they are sure that parents and carers have made lasting changes to whatever difficulties they were experiencing. Sometimes they end their involvement too soon.
- When children and young people cared for by St Helens Council have brothers and sisters, social workers try very hard to keep them together if that is best for them. If children cannot return home, social workers find good homes for them where they are looked after well. Some children go to live with 'forever families' which means they are adopted by new parents. The social workers work very hard to find adoptive families quickly but sometimes this can take too long.
- When children and young people are looked after by the Council, many do not do as well in school as they should. Much more work needs to be done to make sure that children and young people make good progress at school and have enough qualifications to get jobs or go on to college or university. Care leavers need much more help and need lots of information about their lives, their health and what they are entitled to that will help them to successfully live independently. They get good support to find a safe place to live and some care leavers continue to live with their foster carers. More foster carers should be supported to look after young people after their 18th birthday if that is what young people want.

Information about this local authority area[3]

Children living in this area

- Approximately 36,271 children and young people under the age of 18 years live in St Helens. This is 21% of the total population in the area.
- Approximately 23.7% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 22.6% (the national average is 18.0%)
  - in secondary schools is 18.9% (the national average is 15.7%).
- Children and young people from minority ethnic groups account for 3.1% of all children living in the area, compared with 21.1% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are White Other (which includes Eastern European children) at 0.82% and Mixed White and Black Caribbean at 0.51%.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 2.1% (the national average is 18.7%)
  - in secondary schools is 1.2% (the national average is 14.3%).
- Over recent years there has been an influx of Eastern European migrants to St Helens seeking employment opportunities. The Borough's largest distinct ethnic group are Irish travellers.

Child protection in this area

- At 31 March 2014, 1,505 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 1,559 at 31 March 2013. At 6 November 2014 this figure was 1,535.
- At 31 March 2014, 231 children and young people were the subject of a child protection plan. This is an increase from 156 children at 31 March 2013. At 6 November 2014 there were 257 children subject to a child protection plan.
- At 31 March 2014, 13 children lived in private fostering arrangements. This is an increase from 12 children at 31 March 2013. At 6 November 2014 there were 13 children privately fostered.

[3] 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.

Children looked after in this area

- At 6 November 2014, 412 children were being looked after by the local authority (a rate of 114 per 10,000 children). This is a reduction from 432 (119 per 10,000 children) at 31 March 2014. Of this number:
  - 185 (or 45%) live outside the local authority area
  - 25 live in residential children's homes, of whom 44% live out of the authority area
  - one child lives in a residential special school[4] and lives out of the authority area
  - 317 live with foster families, of whom 45% live out of the authority area
  - 36 live with parents, of whom 3% live out of the authority area
  - one child is an unaccompanied asylum-seeking child.
- In the last 12 months:
  - there have been 20 adoptions
  - 30 children became subjects of special guardianship orders
  - 130 children ceased to be looked after, of whom 3.1% subsequently returned to be looked after
  - 12 children and young people ceased to be looked after and moved on to independent living
  - no children and young people ceased to be looked after and are now living in houses of multiple occupations.

Other Ofsted inspections

- The local authority operates two children's homes. Both were judged to be good or outstanding in their most recent Ofsted inspection.

Other information about this area

- The Director of Children's Services has been in post since August 2012.
- The Chair of the LSCB has been in post since June 2012.

[4] These are residential special schools that look after children for fewer than 295 days

Inspection judgements about the local authority

Key judgement	Judgement grade
The experiences and progress of children who need help and protection	Requires Improvement

Summary

- The local authority has embarked on a wide range of improvement work, resulting in much change to organisational structures and work processes in early help and protection. Many have been implemented in recent months and are yet to show significant impact, and some are yet to be fully implemented. Not all children and young people are receiving the help they need at the right time. Thresholds for access to children's social care are not sufficiently understood by partner agencies, which results in too many inappropriate referrals; some are of poor quality. Despite this, referrals are dealt with in a timely manner and signposted to universal services or children's social care as appropriate.
- Of those referred to children's social care, too many have not received support early enough or for long enough to prevent problems escalating There is a high prevalence of domestic violence in the area but services for children and their families affected by domestic abuse are underdeveloped.
- Too many children experience repeat referrals and child protection plans before a stable, safe future is achieved. Other children and families are subjected unnecessarily to intrusive child protection enquiries before the threshold for significant harm is established.
- When risk of significant harm is established, often through a significant incident, there is a swift and robust response but strategy meetings do not routinely benefit from multi-agency information sharing.
- Assessments are mostly timely, though the quality is inconsistent. Not all assessments analyse historical risk factors sufficiently nor evidence the wishes, feelings and experiences of the child.
- Thresholds for escalation to child protection or step down to children in need are not sufficiently understood nor applied.
- Plans often mirror assessments, with too many being unclear about what needs to change by when, and lacking a robust alternative if change does not occur. Child protection conferences and core groups take place regularly, but too many children are stepped down from protection plans without sufficient evidence that change has been achieved and sustained.
- Team managers are not scrutinising or challenging social work practice robustly enough.

45. The early intervention service was restructured in July 2014. Social work-led teams of family support workers have been created who respond to the needs of families identified at level three on the Welfare Continuum of Need. However, there is confusion around this work. Although Children in Need (CIN) single assessments are undertaken in the duty teams, the majority of children in need cases referred into the local authority are managed in the early intervention service. These cases are held by social workers who use the Common Assessment Framework (CAF) even though the threshold for a child in need assessment has been met. CAF assessments do not explore more complex needs, which means that children's needs are not being sufficiently recognised or understood. Too often cases are stepped down inappropriately to universal services when their needs require more in-depth assessment and support.

46. Some partners are not using the Electronic Common Assessment Framework (E-CAF), which means that some children are not benefiting from an early assessment of their needs and early opportunities to improve children's outcomes can be missed. Some professionals within schools are unwilling to act as lead professional for children with lower level needs. This means that cases are often closed without support being provided to prevent problems getting worse.

47. When families with chronic, or often acute, needs show some improvement and no longer require a social work service, there is not enough support from other services to help them to sustain change. When partner agencies refuse to provide lower level support there is limited evidence of effective multi-agency escalation processes being used to address this. In September 2014, two early help managers were appointed. This has begun to have an impact on direct management oversight and monitoring of cases that had been open to children's social care for too long, some for as long as two years.

48. There is a broad range of targeted services in place for children and young people when difficulties emerge. The early help offer from the local authority aims to provide a more coordinated, targeted service from children's centres, with targeted support by family intervention practitioners as a core part of the offer. The authority's Priority Families Programme is now located alongside the Early Intervention Service. This is beginning to show some positive outcomes. Examples of recent improvements can be seen in the provision of speech and language therapy and a robust focus on parenting support. There is good access to accommodation for vulnerable teenagers, substance misuse services (for both adults and young people) and those presenting with conduct or behaviour difficulties. Individual packages of home-based support and parenting advice by family intervention workers are valued by parents. The use of Family Action Meetings (FAM) is well-established, but parents do not receive reports prior to these meetings; this makes it more difficult for them, and young people, to fully engage in the process or raise all matters that concern them.

49. The majority of children in alternative education are receiving considerably less than their 25 hours entitlement; 55% have less than 15 hours provision whilst a further 20% have five hours or less. The vast majority of these children are receiving additional early help services from the Priority Families Programme due to a variety of social care needs, which means that the local authority is in touch with this cohort of children. However early help assessments and plans do not focus sufficiently on children's educational development, which is most often overshadowed by social care needs.

50. The early help offer to children and families affected by domestic violence is underdeveloped. There is a high incidence of domestic violence in the borough with 5,681 referrals being made to children's social care between Oct 2013-Sept 2014. There has been an increase in high risk cases in the half year between April-November 2014 with 393 cases referred to Multi-Agency Risk Assessment Conferences (MARAC) in comparison with 432 cases for the full year 2013-14. Early help pathways are not yet fully developed to address this prevalence in the Continuum of Need. There is a lack of service provision to support children and young people who have experienced domestic abuse with not enough direct work with children or access to counselling, and limited access to adult perpetrator programmes. There is no single risk assessment tool for domestic violence across partner agencies, which means that professionals are not helped to identify risk.

51. The LSCB has very recently driven the implementation of Operation Encompass, which is improving communication and coordination between schools and the police about domestic violence incidents. When a domestic incident occurs, police immediately notify the child's school, which ensures that a designated member of staff makes contact with the child to assess the level of support required.

52. Information sharing at MARAC and as part of the Multi-Agency Public Protection Arrangements (MAPPA) is not being used effectively to communicate risks to children's social care where children are not open cases. This means that for this cohort of children there are missed opportunities to provide early help and assess where children may be suffering harm from exposure to domestic abuse or unsafe adults.

53. There is considerable joint work undertaken between agencies when issues of misuse of drugs or alcohol for either adults or children are identified in a child's single assessment. Parental mental health needs are mostly recognised with joint work being undertaken, but there are examples where assessments and plans have not been fully coordinated between agencies, which means that information needed to inform assessments can be missed.

54. There are persistently high referral rates to social care, which are well above those in similar authorities. This increased by almost a quarter between 2012-13 and 2013-14 to 812 per 10,000 children. The national level is 573 per 10,000 and for neighbouring authorities is 686 per 10,000. This includes a substantial number of re-referrals, as high as 29% in the past eight months compared to 21.9% 2013-14.The majority of children with disabilities seeking social and leisure opportunities do so through a statutory social work assessment when they have no other presenting social care needs. This means that this group of children do not have equal access to services and are subjected to unnecessary statutory interventions.

55. Many referrals to children's social care are inappropriate. Not all agency partners complete the service request form and some referrals do not contain enough information. Valuable resources are wasted while social workers seek enough information to make a determination about next steps. There are no clear arrangements for agencies to seek advice regarding referrals, and almost all contacts result in a referral. Of those contacts sampled by inspectors, four of 14 did not meet the threshold for intervention. Many come from police and schools; the former often relate to domestic violence. The police acknowledge that over 700 domestic abuse notifications are sent to children's social care each month without the required triage and risk assessment; they agreed with inspectors that the local authority is inundated with these notifications. During the inspection, Merseyside police proposed improved risk assessment arrangements which have the potential to reduce notifications by around one third, however no implementation date has yet been set.

56. Once accepted, all referrals seen received a rapid response to concerns, including those out of hours. Consent to enquiries and assessment is sought where appropriate. Management decisions in the first response team are clearly recorded and communication with duty teams for the transfer of cases is effective. In many cases, however, the transfer is so rapid that not all information is either acquired or considered prior to determining next steps, including child protection enquiries.

57. There were no cases seen by inspectors where initial child protection concerns had not been acted on. The co-location of police and social care in January 2014 has not yet however developed into a functional MASH and is not yet leading to improvements in child protection work. This is acknowledged by the local authority as a gap, with some key agencies, notably health and adult services, yet to join. Information sharing is not always timely.

58. Screening by first response social workers is robust. Thresholds for responding to evidenced child protection concerns are appropriate, with actual and potential risks identified. However, decision-making points for child protection enquiries operate at too low a threshold, resulting in too many children being subject to enquiries before sufficient assessment and consideration of agency information. The number of child protection strategy meetings rose by 20% in 2013–14. This was twice the national average increase. Some records of strategy discussions are limited in identifying the risk of significant harm, or the range of actions planned, and some can take several weeks to record. The majority of strategy discussions also only involve social care and the police, so the richness of multi-agency information is not accessed to inform decisions or contingency planning.

59. Of 458 children subject to child protection enquiries, only 154 (34%) proceeded to initial child protection conference. Those decisions are appropriate, but this indicates that many families have been subject to these enquiries unnecessarily. Where cases proceed to initial child protection conference, interim protection arrangements are unclear and poorly recorded.

60. Child protection enquiries are undertaken by suitably qualified social workers. Children are seen alone where appropriate, with practitioners routinely seeking their views about incidents, injuries and recent events, although their broader wishes and feelings are not always clear.

61. Inspectors noted some creative methods used by practitioners engaging and communicating with younger children to gain their wishes and feelings, including observations of non-verbal children. This positive practice does not extend to meeting the communication needs of all children with disabilities. There is no telephone facility for those with hearing impairments and few practitioners trained in common alternative communication methods, such as Makaton.

62. The greater part of safeguarding work is responding to chronic neglect, and the local authority has taken steps to increase awareness of neglect across the children's social care workforce and with partner agencies, but as yet there is limited evidence of the impact of this work. Case files do not evidence use of the recently introduced graded care profile for identifying neglect.

63. The timeliness of assessment is improving. There is evidence that children are seen during assessments in the majority of cases. Since April 2014 there is evidence of clearer management direction, although assessment quality remains variable. Not enough assessments evidence use of the recently introduced signs of safety model or graded care profile to support effective analysis of risk. Insufficient attention is given to the family history or the impact of parental behaviour.

64. Chronologies are not used to support assessments and therefore do not enable social workers to recognise the cumulative impact of abuse on children. There is little evidence that the impact of domestic abuse on children's emotional and physical safety is understood. The impact of faith, culture and disability does not have a high enough profile.

65. The majority of single assessments are undertaken when children's cases are stepped down from child protection plans or child protection enquiries. This means that child protection processes are being used as a precautionary measure to ensure that risks are identified. Whilst immediate risks are not missed, this has unintended consequences for children and their families as they are exposed to intrusive interventions which are disproportionate to their level of need.

66. Inspectors identified a small number of cases where risks had not been sufficiently identified, exposing children to potential harm. One case sampled by inspectors found that risks to two very young children had not been sufficiently assessed prior to them returning home from care. The inspectors concerns resulted in the local authority quickly escalating the cases to a child protection conference and legal advice being sought. The local authority also immediately reviewed and amended their return home policy to include a service manager's agreement before decisions are taken to return a child home from care.

67. Children in need plans are not sufficiently clear about what needs to change and by when, and what support is to be offered. Too many cases are 'stepped down' from child protection to children in need and early intervention teams with insufficient evidence that change has been achieved and sustained. Inspectors found one case of children not being visited for seven weeks following step-down from a child protection plan, and indications in two cases of proposals having been made by managers to remove child protection plans without evidence that risks had been reduced. Robust challenge by the conference chair in both cases prevented the plan from being stepped down.

68. The proportion of child protection plans ceasing after the three month review is 23%, which is above the national average of 20.3%. The proportion of cases ceasing as a child in need within three months of ending the child protection plan is 37.1%, which is considerably higher than the national average of 25.4%. Some children subject to child protection planning still experience some drift and delay. This is not being consistently identified and challenged by conference chairs and managers. Change is not being robustly driven through conferences and core groups. Not all protection plans are specific about how risks are going to be managed and how children and their families are to be supported and not all core group minutes show how progress is being measured against protection plans. Timescales for change and what action will be taken if children's circumstances do not improve are unclear in the majority of plans seen. Team managers are not quality assuring protection plans or reviewing whether interventions have been effective and robust.

69. Of the 311 children with current child protection plans, or closed within the previous three months, 32% had previously been subject to a child protection plan for similar reasons. This demonstrates that parents and carers have been unable to sustain the necessary changes therefore exposing children and young people to further harm. This figure has reduced in recent months, but there continue to be a significant number of cases where too little is changing and where there is change, this is too slow.

70. A large majority of child protection plans are in place because of neglect or risk of emotional harm. Nearly half (46%) of children subject to protection plans show neglect as the category of abuse, and emotional abuse is the category for 40% of cases. Some child protection plans are compromised by the limitations of the assessment and some are too adult focused with children's needs often swamped by adult issues.

71. A vast majority of early help and protection plans tracked by inspectors failed to focus sufficiently on the underlying risks and need. This means that outcomes sought for children are not informed by robust assessment of need. Some are not recorded clearly enough and lack timescales for achieving sustainable change.

72. Child protection reviews are mostly undertaken within timescales (88%), but this is still below the authority's own target of 96%. Statutory visits when children are subject to child protection plans are timely however the purpose of visits is not always well recorded and it is unclear from records how these visits are monitoring and contributing to the progress of plans. Case files do not always present evidence of direct work undertaken with children or reflect the knowledge social workers have of the child.

73. Since April 2014, there is increasing evidence of children being considered within pre-proceedings and legal planning frameworks. This is the result of appropriate assertive action with a clearer perspective on seeking permanence, particularly for pre-school children. Pre-birth assessments are also receiving more rigorous assessment of risks and needs within a more focused timescale.

74. It is acknowledged by the local authority that children and young people's voices are not sufficiently heard and understood. Children are not being supported enough to participate in child protection conferences and children's views are not routinely being sought to contribute to service development and improvement. The recent commissioning of the National Youth Advocacy Service (NYAS) aims to address this. Every child subject to child protection processes are now being offered an advocate to support their participation in assessments and meetings which concern them, subject to the child or young person's age and level of understanding. This service is however so recent that the impact of this is yet to be fully demonstrated further awareness-raising training for social workers is also planned to support placing the child at the heart of their work.

75. Procedures for children missing education are thorough and cover a range of eventualities. Procedures provide clarity for all professionals as to the role of different services and give advice why different groups might be missing education. School attendance is robustly monitored and communicated to children's services as appropriate. The policy to pursue children missing from education is well demonstrated in a number of cases seen by inspectors involving Education Welfare Officers tracking children and in one case exhausting local enquiries and extending its search into Europe to establish the whereabouts of a missing child.

76. There are currently 46 children in St. Helens where parents are opting for Elective Home Education (EHE) for their children. The LSCB reviewed arrangements for children who were effectively home educated, some of whom had not been visited for two years. As a result of this work the local authority ensured that every such child was visited and a new protocol was implemented to strengthen the safeguarding and educational oversight of those children following this a number of children re-entered mainstream education. The Local Authority has also been requested to participate within a national initiative to address safeguarding with an EHE context.

77. In June 2014 the local authority commissioned Catch 22 to provide a dedicated missing from home and care service, which has begun to provide an active, energetic approach to identifying children and young people who are at risk of CSE. As this service is so recent, the findings have not yet been analysed by the local authority or police to inform service planning around risk management and support. The work of Catch 22 is not familiar to all social workers, and findings from return home interviews are not yet informing children's plans, which is a significant gap. Social workers do not routinely use a specific risk assessment tool with children where there may be a CSE concern, which means opportunities to identify children and young people potentially at risk are being missed.

78. A dedicated missing from home worker is located in the first response team. Children at risk of CSE are managed through the developing Multi-Agency Child Sexual Exploitation (MACSE) arrangement. In the past 12 months, 19 cases have been discussed at MASCE: eight looked after children, one care leaver, two children in need and eight children not previously known to children's social care. Whilst strategic intelligence sharing at MASCE is improving, this is not routinely informing children's plans. In four out of five cases sampled by inspectors, strategic information sharing did not translate onto children and young people's files and no safe care strategies were recorded. Where matters of actual or likely harm are identified, the police are active in pursuing prosecutions. However, current police and social care capacity to routinely analyse and evaluate patterns that may lead to prevention or disruption activity is limited.

79. Procedures for identifying children who are privately fostered are appropriate however there has been no publicity or awareness raising since April 2013. At the time of the inspection 13 notifications were actively being worked. The majority of initial assessments seen by inspectors do not provide holistic assessments of the child's needs and circumstances, which means that the needs of this vulnerable group of children are not well understood.

80. The management of allegations against professionals is effective. There is a timely initial response to referrals from the Local Authority Designated Officer (LADO), although follow up meetings to track the progress of investigations can take longer than they should to be completed. The vast majority of referrals are made by schools, residential children's homes and the fostering service. The annual report does not sufficiently analyse where there are gaps in agencies reporting to the LADO. This limits the ability to use this information to target agencies and ensure that the LADO's role and function is understood across the partnership.

81. A consistently constructive and coordinated response between social care and the local social housing agency, Helena, is in place for homeless 16- and 17-year-olds. A dedicated young person's accommodation officer robustly assesses young people's needs and provides ongoing support to ensure that they become settled in accommodation, including advice on benefits, education and employment. While some are supported by mediation to return back to their families, the majority are provided with dedicated emergency supported accommodation. The council is compliant with the Southwark Judgement and ensures that where appropriate young people are accommodated under Section 20 of the Children Act 1989. The local authority does not use bed and breakfast for these vulnerable young people.

Key judgement	Judgement grade
The experiences and progress of children looked after and achieving permanence	Requires Improvement

Summary

- There are currently 412 children looked after by St Helens' council. The rate of looked after children has been consistently higher than both the national level and statistical neighbours.
- At 31 March 2014 St. Helens had 430 looked after children at a rate of 119 per 10,000, this was almost double the national level of 60 per 10,000 and substantially above neighbouring authorities at a level of 74 per 10,000. This is in part due to action to address drift in a significant number of neglect cases but also a lack of effective early help services.
- Decisions to look after children are now more timely and no cases were seen where children were looked after unnecessarily.
- The educational achievement of looked after children is poor and based on starting points, the progress achieved is too slow. The most recent results show that on average, pupils at Key Stage 4 are at least 32 months behind pupils nationally. Personal Education Plans (PEPs) do not focus sufficiently on children's educational attainment. Too many care leavers are not in education; employment and training, with only four accessing higher education. The lack of aspiration and priority afforded to the education of both looked after children and care leavers by corporate parents is seriously compromising their life chances.
- Implementation of the Public Law Outline (PLO) process has helped to reduce the time it takes to complete care proceedings and to make plans for children's permanent care. Plans to return children home from care when they are not subject to legal proceedings are not sufficiently informed by robust assessments to ensure that risks have been reduced and change can be sustained.
- Assessments and care plans are not consistently updated and some lack detailed information about important events in children's lives. Not all children have looked after plans which reflect their current and emerging needs or which are informed by their wishes and feelings. Not all looked after children receive a timely initial health assessment.
- Arrangements for assessing risk and keeping young people safe from CSE, especially when they go missing, are not yet fully understood by all staff.
- Almost all care leavers remain looked after until they reach 18 years of age, and the local authority is in touch with all of them; however, few care leavers remain with their foster carers beyond 18 years of age. The range and standard of accommodation for care leavers is good, but the current location of the care leavers' service does not provide opportunities for direct work with young people.
- Care leavers have insufficient information about their medical histories and entitlements. Pathway plans and reviews are not clear enough about the support

young people need and how this will be achieved.

- Some children awaiting adoption have waited, and continue to wait, too long before being placed with their adopters; a number have already waited in excess of government targets. However, the local authority does work hard to find adoptive parents for hard to place children and children with complex needs, with positive outcomes. There are delays in completing life story work with children to help them understand their background and to prepare them for adoption.
- There are good quality foster placements and residential provision. Placement stability is also good. There is decisive action to find families and match children appropriately.

82. There are currently 412 children looked after by St Helens council. The number of looked after children has continued to be high compared to statistical neighbours. This is a result of positive action taken in the early help and protection services on a number of cases which had drifted which has resulted in children being taken out of situations of risk who are now living in safe and stable placements. Thresholds for becoming looked after are now understood and applied consistently. Legal planning meetings are chaired by senior managers which ensure that children do not become looked after unnecessarily and provides an additional level of scrutiny to ensure all alternatives to care have been explored.

83. Where the plan is for a child to return home, assessments to determine if the risks which led to the child becoming looked after were not robust in a small minority of cases sampled. This means that children are sometimes returning home without purposeful work to ensure that the family can sustain change.

84. The local authority is using the Public Law Outline (PLO) effectively to reduce the average duration of care proceedings to within 24 weeks, against a national average of 31 weeks. Inspectors saw some good examples of parallel planning, which means that children and young people are waiting less time to achieve legal permanence. Whilst Cafcass reports that the quality of care applications is improving, the quality of social work practice prior to care proceedings being initiated is not consistently good or well evidenced. Letters before proceedings are well written and expectations of parents are clear, but management oversight of decisions and progress monitoring of pre-proceedings work is not always robust. The result is delay for some children where further assessments and information is needed to analyse risk.

85. Looked after children's current and emerging needs are not well understood in the majority of cases seen, as assessments are not routinely updated. In a small number of cases, assessments had not been updated for several years. This means that plans lack important information about things that have changed for children, and in some cases plans have drifted without the right intervention or actions.

86. Only a minority of cases sampled by inspectors considered children's needs arising from their cultural or ethnic identity. Children's needs in relation to contact with family members are not well recorded. The majority of plans seen did not routinely record children's views and wishes or reflect how they are involved in the planning process. Inspectors did see some examples of better plans, which contained the views of children and included clear timescales and contingency planning.

87. The educational progress and attainment of looked after children is not given sufficient priority either at an operational or corporate level. Social care assessments and plans do not focus enough on children's educational needs. There is still more work to do in relation to school readiness. At Key Stages 1 and 2, looked after children make progress which is in line with expectations nationally, and a few reach the higher levels in Key Stage 2. The majority of looked after children in Year 1 reach a good level of development in the phonics screening checks, but only a small minority reach a good level of development in early years.

88. The quality of PEPs is not consistently good; they lack sharpness, fail to focus on educational outcomes and do not consider whether pupil premium funding is being used to support children's progress. This means that children and young people are not supported to achieve their full potential and opportunities are missed to identify where children need additional help. This is reflected in the poor GSCE results for young people at Key Stage 4 and the low numbers of young people accessing higher education and employment when they leave care.

89. The majority of looked after children attend good or better schools, attendance is above the national average and behaviour is well managed. There have been no permanent exclusions of looked after children in the past four years and fixed term exclusions are well below the national average, at 6.3%. Despite these positive indicators, standards and aspirations for looked after children are too low.

90. Progress during Key Stage 4 is too slow, and GCSE results are poor and have varied considerably over the last four years. Improvements when made are not sustained and standards are not high enough when compared with statistical neighbours. Low results mean that when looked after children leave school at age 16 they are on average 32 months behind in their learning.

91. In 2014, one quarter of year 11 looked after children were identified as having special educational needs. By the end of year 11 the overall progress of this cohort was below the expected progress for similar groups both within the local authority and nationally.

92. The local authority has been slow to appoint a dedicated Virtual School Head teacher, and planning for improvement has only recently started with a restructure of the virtual school. The appointment of a part-time head teacher from a previously outstanding school is a step forward; the new appointee should challenge the culture of low expectations and ambition for looked after children and lead on an action plan to improve progress and attainment at all key stages.

93. Statutory social work visits to looked after children are carried out within timescales and recorded on children's files, and most social workers spoken to could add rich context about the child and their lived experiences. It was clear that social workers were helping many children to understand the reasons for becoming looked after. There were some good examples of observations of very young children being used to understand their wishes and feelings.

94. Caseloads in looked after children teams are too high. Some social workers are holding up to 30 cases, which affects their capacity to see children consistently and undertake direct work in all cases.

95. The Independent Reviewing Service is not always fulfilling its statutory responsibilities. Independent Reviewing Officers (IROs) do not contact all children before reviews, although they do prioritise those children who live outside the borough and make visits to those children who do not attend their own meetings to explain any decisions made. There is evidence on case files of IROs challenging plans where there is a lack of progress for children, although this does not always result in actions to improve social work practice or expedite the child's plan.

96. Written reports are not always provided to reviews by social workers and other professionals, which means that the IRO is unable to prepare ahead of the meeting and children and parents do not know what is going to be said about them. The local authority is not yet meeting its own target for reviewing children's plans in a timely manner. In September 2014, only 85% of reviews were completed within timescales against a target of 96%. Very recent steps have been taken to address this issue by recruiting additional IRO capacity.

97. Achieving permanence for children is given priority in planning. It is supported well by clear policies and guidance for staff. A permanency panel meets regularly to consider children's needs and potential matches. Life story work for children with a plan for permanence is not delivered consistently, and too much reliance is placed on foster carers to complete this vital work.

98. Placement stability is good and has improved year on year for the past five years. Placement stability at year end 2012-13 was 67.3% Between April and September 2014, 71.3% of children had been in the same placement for two years or more. Of the 143 children who have been looked after for more than 2.5 years, 102 children and young people have been in the same placement for at least two years. Short term stability is also good, with only 39 children (7%) having had three or more placements over a three-year period against a national average of 11%.

99. There is a mixture of in-house and agency foster carers who provide a range of placements for children which helps to prevent placement disruption. Foster carers spoken to feel well supported. Providers of agency foster carers report that the authority provides flexible help and support to placements. Suitable monitoring and quality assurance processes are in place to ensure that residential placements continue to meet statutory requirements and the needs of children and young people.

100. There are 186 looked after children and young people living outside the local authority area, of which the majority, 156, live within 20 miles of their home address. There are 30 children who live more than 20 miles from their home of whom the majority, 15, have been in the same placement for more than two years. Social work visits to children living outside the area are prioritised.

101. The local authority has a family and friends carers' policy, and priority is given to assessments of family members who come forward as potential carers for children during court proceedings. However, the recent prioritisation of these assessments has had a negative impact on the capacity of the fostering service to complete the assessment of new foster carers and has also led to delays in the training provided. This compares to the effective recruitment performance in 2013–14 which showed an increase of 50% from the previous year. At the time of inspection there were; 29 family and friends and 22 prospective applicants in the process of assessment. A total of 35 foster carers have left the authority since September 2013.

102. There is a strong commitment and drive to promote the use of Special Guardianship Orders (SGOs) to secure legal permanence for children and young people with their carers. Focused work has resulted in 44 children ceasing to be looked after in 2013–2014 via SGO arrangements. Foster carers are supported if they want to apply for a SGO, but not all foster carers were clear about the levels of financial support available to them. Since September 2013 nine foster carers have become special guardians and two are currently being assessed.

103. The quality of assessment of foster carers is improving and annual reviews are undertaken within timescales. The fostering panel is led effectively by an experienced independent chairperson. Panel membership is appropriate and includes an elected member, who ensures that there is a good link to corporate parenting. Minutes show that the panel meets regularly and that members are appropriately challenging of social workers' presentations in order to contribute to and improve practice.

104. Most looked after children and young people said that they like their social workers and can talk to them about most things. Children told inspectors that they feel safe at home and school but, importantly, they know what to do if they are unhappy. Young people could describe examples of when things had changed because they had told their social worker about something. Children knew how to report bullying and where to go for help.

105. The work of the Children in Care Council (CICC) was recognised by the Children and Young People Now Awards 2013, where they received second place under the category Best Children in Care Council. Members of the CICC said that they feel listened to in a genuine way and feel that their opinions are valued. They gave examples of changes that had been made to the leaving care allowance and to pocket money levels because they had spoken directly to the Director of Children's Services.

106. All young people looked after are offered a service from the National Youth Advocacy Service (NYAS) and are offered the support of an advocate to promote their participation in their reviews. Young people know how to complain and those who do are offered a service from an advocate. The majority of complaints are resolved at the informal stage and are dealt with promptly. Children and young people are encouraged to make friendships and to have hobbies and interests, and are supported to try new activities.

107. Looked after children are over-represented in the youth justice system. Of the 88 young people who received a substantive outcome between April and September 2014, 15% were looked after children. A dedicated Youth Offending worker has recently been appointed to ensure that looked after young people are not entering the system unnecessarily.

108. Recent improvements have been made to help ensure that looked after children have their medical assessments on time, but targets are still not being met and the percentage of medical assessments completed within timescales fell to 85%, from 89% in the previous year. This means that some children's health needs are not understood and addressed in a timely way.

109. There is a wide and innovative range of services to support children's mental health and well-being. The emotional well-being panel creates bespoke packages of support from a range of providers including CAMHS and NSPCC. Children and young people who misuse substances and alcohol are well supported by Youth Action Against Addiction who provide support through transitions into adult services for care leavers.

110. There is evidence of good support for children with disabilities in short break accommodation and respite services. Parents spoken to were positive about the experiences for their children, and value the practical and emotional support arrangements. However, none of the children's plans seen during the inspection were up to date which means children's plans did not reflect their changing and emerging needs.

111. When children go missing from care a commissioned service, Catch 22, provides return interviews for all children, including those who live out of the borough. Since June 2014, all children who have more than one episode of being missing are risk assessed for CSE and all children are offered ongoing work from Catch 22. However, social workers do not have a full understanding of this work and do not routinely receive the outcome of assessments. Children's plans are therefore not being informed by this work. Information from these interviews is collated by the provider to identify patterns and trends, but this work is so recent that the first quarterly report has only just been provided to the local authority and is yet to be evaluated and analysed to inform strategic planning.

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

112. Some children have waited, and continue to wait, too long between becoming looked after and being placed with their adopters. In 2013–14 the average number of days a child living in St Helens waited to be adopted was 629. This has increased since the last published figures and is further away from the 2012 - 2015 government target of 487 days. In the year to date, the average time has reduced to 629 days but this remains 142 days away from the target.

113. The average time taken to place a child with adopters after a court order has been made has also increased since the last published figures, from 205 days in 2013–14 to 231 days for the year to date. This is 110 days above the 2012 - 2015 target of 121 days. Whilst there is delay in meeting government targets, some of this has been unavoidable due to the complex needs of some children with plans for adoption. There has been no drift in social workers' family finding for children who are harder to place. Social workers are tenacious and do not give up which will affect performance in relation to the national adoption scorecard. The authority understands this challenge well and continues to pursue adoption where it is in a child's best interests, which is good practice.

114. In order to improve performance, in April 2014 each local authority brought their adoption social workers back from the tri-borough service, WWISH, which had been responsible for adoption since October 2011. Capacity in the adoption team was increased and a permanence coordinator role created. Improved, comprehensive and robust monitoring and tracking of adoption plans was implemented. As a result, the time between coming into care and being placed for adoption is beginning to reduce.

115. Recruitment, approval and support for adopters continues to be provided by WWISH. Regular meetings take place with the permanence coordinator to discuss children waiting and potential adopters. Recruitment is informed well by the needs of children waiting and also targeted for older children, siblings and for children where their developmental progress is uncertain. Assessments are prioritised accordingly.

116. WWISH recruited 71 families across the three boroughs in 2013–14 as a result of successful recruitment campaigns. However, this large number affected the service's capacity to carry out prompt initial home visits to people considering adoption.

117. WWISH has struggled at times to meet the demand for assessments, and therefore makes regular use of a small pool of experienced independent social workers. Despite this, WWISH has been unable to provide assessors for foster carers of 14 children, who have recently come forward to be assessed as adopters. As a result, St Helens has very recently commissioned these assessments from other independent social workers. Stage 1 of the approval process is not always completed within two months, and adopters said that they experienced delays in receiving initial home visits. WWISH reports some delays at stage 1 due to late receipt of medical reports and the need to obtain checks from overseas agencies.

118. Since April 2014 there has been strong and well-informed management oversight of adoption work. Staff are passionate about achieving adoption for all children who are unable to live with their birth family, placing siblings together where possible and promoting contact between siblings where appropriate if placement together is not possible. Children are beginning to benefit from fostering for adoption placements, with 14 children placed with their adopters from birth. This is good performance. The permanence coordinator ensures that family finding enquiries begin promptly through effective communication with social work teams and timely forward planning.

119. The Agency Decision Maker (ADM) is a senior officer and has the required knowledge and understanding of adoption to provide robust challenge to the panel chair when this is appropriate. Priority is given to the consideration of Best Interests decisions, which are made following careful scrutiny of each case. No adoption disruptions have occurred in the past three years. The ADM makes any decisions to change a child's adoption plan and ensures that the reasons are appropriate. Usually it is because the child's needs or background are such that, despite prolonged family finding, a suitable adopter cannot be found. When plans are changed, purposeful alternative permanency planning takes place.

120. Once children are identified, the adoption tracker is effective in ensuring that the progress of the 88 children who currently have an adoption plan or a likely adoption plan is monitored at each stage. Since April 2014, fourteen children have been adopted. This is more than in each of the previous three years and represents 19% of children discharged from care.

121. Effective monitoring means that the adoption service knows exactly the position for the 37 children who are not yet placed. As a result, family finding is focussing on those 11 children for whom adopters have not yet been identified. All family finding work is diligent, creative, tenacious and extensive. Time is not wasted as there is up-to-date intelligence about families available through WWISH and the two Voluntary Adoption Agencies used by the authority. Children's profiles are circulated promptly through the regional group, Adopt North West, Be My Parent and other national links. The authority has used adoption activity days and another is planned. The adoption team does not like to 'give up' and, as a result, some children with complex needs or challenging backgrounds, older children and siblings have eventually been placed. This inevitably means performance against the scorecard will be negatively affected, but the outcomes for the children are positive.

122. There are ongoing delays in completion of life story work for some children. This is linked to capacity within the adoption team to do this work, and arrangements are now in place with a voluntary agency to address this. Children experience helpful direct work from their foster carers and social workers to help them understand what has happened in their lives, and to prepare them for adoption; for example, memory boxes are created and they are helped to complete 'all about me' booklets.

123. Adopters are complimentary about the support from the adoption team, which provides good pre-placement information about the children prior to formal matching and facilitates meetings with foster carers and nursery/school key workers. Introductions are well planned and move at the child's pace. Regular visits and reviews take place. Adopters value the continuity of IROs because they know the child well. The decision about when to apply for an adoption order is discussed appropriately. None of the adopters spoken to said that they felt they were being either pushed or slowed down in moving to the next stage saying 'It's going at our pace'.

124. Following a review of the service, training sessions are now offered by WWISH alongside assessment to provide adopters with information and promote their understanding about a range of issues. This includes the impact on child development of substance and alcohol misuse, foetal alcohol syndrome, parental mental ill-health, attachment, and neglect. This preparation helps applicants to make an informed choice about children whose needs they can meet and what support they will need before and after children are placed. Adopters are positive about their experience and the benefits gained and said it had helped them once children were in placement.

125. The WWISH adoption panel is chaired by a knowledgeable and experienced independent chairperson. The membership of the panel is appropriate, attendance is good and panels are always quorate. Panel members provide social workers with constructive, robust challenge and give feedback to improve practice.

126. The panel chair considers that the quality of assessments is generally good and the quality of analysis is improving. Similarly, children's permanence reports, matching information and adoption support plans are usually of a good quality and provide panel members with the information that they need. This is supported by the inspector's findings from the evaluation of case files. Panel minutes are comprehensive, focus on relevant issues, reflect discussions well and provide the clear reasons for the panel's recommendations. The working relationship with the ADM is effective.

127. Adopters are well supported by their WWISH social worker throughout the adoption process. The adoption service plans to further improve quality and consistency of support plans by using the British Agencies for Adoption and Fostering (BAAF) form from January 2015. Fifty families across the three boroughs have participated in the Webster Stratton parenting programme since 2013. WWISH also provide some direct work with children and individual therapeutic interventions such as play therapy and support adopters with school admissions and any health issues. Specialised support and bespoke packages are also provided by WWISH to new adoptive placements. WWISH provides a well-established post-adoption contact service which is available until the child reaches 18 years of age. There is a dedicated coordinator for each local authority. Of the 359 active post-adoption contacts, 134 are from St Helens. The coordinators monitor the exchange of information, support parties with letter writing, and regularly review each family's contact agreement to ensure that it continues to meet the child's needs. The service also contacts adopters regularly to provide information and to invite them to its regular social events.

128. WWISH provides an access to adoption records service for adopted adults, and the demand for this service is high. Across the three authorities, 31 adopted adults are receiving a service and 56 adults are waiting. A further 15 families are supported with searching and reunifications. The local authority also commissions a service through WWISH for birth parents from Birth Ties (After Adoption), and five birth parents are currently using this service.

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

129. Not enough care leavers are in education, employment or training. At the time of the inspection, of the 71 care leavers, only 32 (45%) were in education, employment or training. This figure is too low, and is a consequence of not enough looked after young people leaving school with appropriate qualifications.

130. Partnership work with the local college and Connexions is contributing to engaging care leavers in finding employment. Nevertheless, with only seven care leavers in apprenticeship schemes, much more needs to be done to increase their employment rate. Only four care leavers are in higher education. Of the 36 apprentices currently working with the local authority, only two are care leavers.

131. Discussion with care leavers indicate that their aspirations are not high and those spoken to did not express sufficient belief in themselves that they can progress on to higher education or employment. Young people spoken to who are in apprenticeships value the experience highly, and the stabilising influence of employment has had an evident positive impact.

132. Pathway plans for care leavers are not clear enough about what needs to happen and by when. They are too often confusing, containing outdated actions and lacking in timescales and contingencies. This makes it difficult to measure the true extent of progress. Plans are reviewed and updated regularly by personal advisors, but this offers no opportunity for scrutiny or independent challenge to the young person when they make poor decisions.

133. Care leavers depend heavily on the positive relationships they have with their personal advisors for information about their rights and entitlements. Leaflets are available, but they are not specific to St Helens and are rarely used. The local authority recognises that this is not preparing young people well for independence, and is currently developing a care leavers' handbook with the assistance of the CICC. Based on feedback from young people, the local authority launched a website for looked after children and care leavers in September 2014. However, not all children and young people have internet access in their placement; whilst 85% of looked after children have access to the internet, only 50% of care leavers do. The local authority intends to review its provision to ensure that all looked after young people and care leavers are able to access the website.

134. The local authority procedures stipulate that a final health assessment is offered to young people leaving care, and that a letter containing their health information is provided. Inspectors met with six care leavers, none of whom reported receiving information about their health history or appeared to know that this information was available to them. More needs to be done to ensure that care leavers take up the service, and that they are reminded how to get their health information if they choose not to attend their final health assessment.

135. The young people's team which works with looked after children over the age of 14 and care leavers is co-located with the youth offending service. This gives an unintentional negative message to young people about the local authority's aspirations for their future. One care leaver told inspectors she did not like going there because if friends see her going into the building they assume she has committed an offence. There are insufficient resources for staff to mentor young people with daily tasks, such as filling in housing applications or making a meal. The local authority has recognised this is a gap in provision and has plans to identify a suitable venue with drop-in facilities.

136. Young people who are in foster care are encouraged to remain in their foster placements after their 18th birthday through the local authority's 'staying put' policy, which was updated in February 2014 and provides clear guidance. Take-up is low, with only three care leavers currently with former carers under a staying put arrangement. There is a good range of supported lodging provision for care leavers who would benefit from a family environment. This service can also respond to emergencies, which is strength. Currently nine care leavers are supported in this way.

137. All care leavers remain looked after until their 18th birthday and therefore benefit from their plans being overseen by independent reviewing officers. The local authority is in touch with all of them. Some young people in cases seen have clearly benefited from enduring relationships which they have built up with workers over time. Others, however, have experienced too many changes of worker at a time when they most need continuity.

138. Transition planning for care leavers within the disabled children's team begins at age 16. Planning for adulthood is often lengthy for these young people due to the complexity of their needs. This can cause uncertainty for them and their carers. In one case seen, an appropriate placement had not been identified at the point of the final looked after children's review. It is unclear how children's services are kept informed that statutory responsibilities are being exercised once care leavers transfer to adult services. The local authority had identified the need to start transition planning for disabled young people earlier as an area for development prior to this inspection. This process has commenced, with all disabled young people now allocated on their 16th birthday to an adult services social worker, who co-works with children's services. This is providing an opportunity for rapport and relationships to develop, and enables the complexities of young people's needs to be well understood before transition to adult social care.

139. When young people need more specialist help, for example due to substance misuse or for their emotional health, their needs are considered by the Emotional Well-being Panel, which reduces delay and ensures that young people are quickly directed to the most appropriate service. Services for care leavers out of area are dependent on local provision. In cases sampled, all of the young people were receiving a similar level of service to those within area and were not disadvantaged by distance. There are acknowledged differences in application of thresholds between children's mental health provision and adult services. However, CAMHS continues to work with young adults who are already receiving a service up to age 19 and services for young adults who misuse substances are readily available and of good quality.

140. At the time of the inspection, 93% (66 of 71) of care leavers were living in suitable accommodation. Although this is not as good as the 100% figure in published data (which reports on where care leavers are living on their 19th birthday), it still represents strong performance. Appropriate action is being taken in all cases where young people are not in suitable accommodation. The range of accommodation available to care leavers is comprehensive. It enables young people to move towards sustaining their own tenancy in incremental steps, with flexible support, at their own pace.

141. The local authority is proactive in identifying gaps in provision and in working with providers to fill the gap. Placement providers are required to demonstrate that they meet appropriately exacting standards. The local authority has identified that risk assessment in relation to location is a gap and these assessments are in the early stages of completion. All of the young people spoken to reported feeling safe in their current accommodation, and that it met their needs.

142. There are five care leavers who regularly attend the CICC, which is known as 'One team one voice'. It takes an active role in championing the needs of care leavers both strategically and in individual cases. The local authority holds a yearly event to celebrate the achievements of looked after children, which includes care leavers. Care leavers spoken to value their relationships with workers and feel valued in return. One young person said "I know I would be six feet under by now if I hadn't come into care".

Key judgement	Judgement grade
Leadership, management and governance	Requires improvement

Summary

- The restructure of early help services and statutory social work teams took place in September 2014 and as such changes are very recent and are not yet embedded. Not all partners are working together to deliver early help and this has not been robustly challenged by senior leaders, elected members or the LSCB.
- Despite the recently refreshed continuum of need document, thresholds for access to children's social care and transition points for children moving through the continuum are not sufficiently understood or applied within social care or across the partnership. Opportunities to prevent children's needs escalating are being missed. Senior leaders within the council have precautionary approach to child protection which has unintended consequences for families, subjecting them to intrusive investigations when lower level support would suffice.
- The local authority as corporate parents has not been an effective champion of children looked after or care leavers. There is insufficient focus on improving the educational progress and achievement of looked after children. Outcomes for the vast majority of children and young people are poor, which is limiting their life chances.
- The quality assurance framework provides some good levels of information and data which is leading to targeted work and service improvements. The action taken to date however has yet to identify all service deficits, in particular deficits in the quality of risk assessment, care planning and thresholds for child protection enquiries. The local authority's self-assessment appropriately identifies strengths, although areas for improvement are not so well understood. Performance management arrangements are compliance driven and there is an insufficient focus on outcomes for children and the quality of social work and front line managers' practice to achieve this.
- The Director of Children's Services (DCS), the Chief Executive Officer (CEO) and elected members of the council understand their roles well. The CEO monitors and holds to account the LSCB Chair. Improvement work has been prioritised and financial support has been secured. Governance arrangements are clearly defined; however, the dissolution of the Children's Trust arrangements in March 2013 has weakened the implementation in some areas of the strategic plan for children and young people. This is particularly in relation to looked after children's attainment; education, employment and training opportunities for care leavers; and the local partnership with the police. The recent formation of a Children's Steering Group should resolve

this.

- The Joint Strategic Needs Analysis (JSNA) effectively prioritises children and the recent co-location of Public Health within children's social care is strengthening strategic planning.
- Commissioning services are strong and there is a comprehensive sufficiency strategy.
- The workforce strategy and supervision policy are of good quality and recruitment and retention rates are also good. However, the quality of social work knowledge and skills is not consistently good or embedded in practice. Training is not systematically evaluated for its impact on practice or yet ensuring consistently good quality practice.
- There is a renewed focus on the voice of the child; however, more work is required to ensure that the lived experiences of children and young people are understood and reflected in case work.

143. The Chief Executive, members and Director Of Children's Services have an awareness of front line practice, strengths and areas for improvement with the exception of child protection processes. Despite regular audits, self-assessment and peer review, whilst strengths are accurately identified thresholds for child protection enquiries and children in need assessments had not been recognised as areas needing improvement.

144. Governance arrangements are now clearly defined. Front line services have been protected from budget cuts. Oversight and challenge by senior leaders, members and the LSCB, although appropriately focused, have not been robust in improving outcomes for children in need of help and protection and looked after children. This is especially so in relation to narrowing the attainment gap between looked after children and their peers and improving employment, education and training opportunities for care leavers. Action has been taken to address these shortfalls, for example, the appointments of a schools commissioner to help schools improve, the appointment of a part-time virtual head teacher and extended provision of the connexions service. These improvements are very recent and are not yet making a difference for children and young people.

145. Since the dissolution of the Children's Trust arrangements in March 2013, strategic partnership arrangements have been managed through the Health and Wellbeing Board, Community Safety Partnership and the Merseyside Domestic Abuse Forum. The Corporate Parenting Forum reports into the Health and Wellbeing Board. Whilst this has secured strong strategic oversight of children and young people's health and public protection arrangements, it has weakened strategic oversight and implementation of the strategic plan for children and young people. This includes improving attainment for looked after children; and education, employment and training opportunities for care leavers. The impact of domestic abuse services has not been driven sufficiently at a local level nor sufficiently challenged by members. This has hindered implementation of the MASH and weakened the strategic focus on reducing, the high number of domestic abuse notifications made by the police that do not meet the threshold for children's social care.

146. Plans have been approved by the council to address this by the formation of a Children's Steering Group to oversee the delivery of the draft children and young people's plan (2014 to 2017) in order to appropriately prioritise services for children. The steering group is due to have its first meeting in December 2014. There are also ongoing discussions with Merseyside police to develop and roll out a model for their risk assessment of domestic abuse incidents, though there is no confirmed timescale for implementation of the domestic abuse risk assessment protocol. There is effective prioritisation of children and young people within the joint strategic needs assessment (JSNA), including early help, and this is helping to formulate a shared set of priorities within the Health and Wellbeing Board and the provision of services based on known prevalence. This includes domestic abuse, substance misuse and adult mental health services. Through a number of intelligence and evidence gathering processes, including the JSNA, the local authority has a good understanding of the key issues facing children. There are 136 adults accessing drug and treatments services, and 57 adults accessing alcohol treatment, who have one or more child living with them. A range of accessible services are appropriately available to meet the needs of children, young people and their families in this regard.

147. The co-location of the Director of Public Health with children's social care is leading to strengthened strategic planning and improved coordination of services for children and families. For example, the review of CAMHS has increased capacity within early help from 285 to 430 young people reducing the time children and young people wait for triage assessments of their emotional needs. Lower-level therapeutic services have been developed which are preventing some children's needs escalating, and creating more capacity within tier three services where children and young people have more complex needs.

148. A children's and health integrated commissioning team has been in place since September 2014 and, although it is early in its development, this is already improving the coordination of services for children. There are clear protocols in place for young people's transition to adult substance misuse services. Transitions for young people into adult mental health services are currently under review. The local authority recognises that this is a gap, with just two young people transferring into adult mental health services since January 2014, and action is being taken to address low numbers with plans to work together with CAMHS and plan effective transitions where appropriate.

149. There are strengthened commissioning arrangements for children, young people and their families and robust contractual oversight of provision and placements. A comprehensive sufficiency strategy, overseen effectively by the Corporate Parenting Forum, evaluates the placement needs of looked after children, making clear and correlated findings on gaps in service provision. Consultation is underway with providers to address the gaps in provision for mother and baby placements and in-house residential placements for older children and young people with more complex needs.

150. There are clear and comprehensive service plans for embedding the vision to improve services for children and families. These are underpinned by a measureable set of performance indicators, which include outcomes to be achieved. However, service plans have not been translated in to team plans, and social work practice is not yet coherently aligned with the workforce development strategy. This is a missed opportunity for operational staff to own the vision and influence service developments and improvements within teams.

151. Performance clinics are chaired by the assistant directors and attended by service managers. Data analysts are contributing to a good oversight and understanding of some performance trends, but this does not include an understanding of children in need cases at tier three or the effectiveness of step down arrangements to tier two, and this is a gap.

152. There is insufficient focus on the quality of practice that sits beneath the data. A substantial number of case file audits have been carried out by managers and externally commissioned services since September 2012 as part of, and in addition to, an established quality assurance framework. This includes an internal wholesale review of looked after children; those children subject to child protection plans; and more recently a review of children receiving early help. Whilst the audit findings have effectively contributed to the restructure of services for children and young people and assured compliance, for example, in ensuring those children experiencing long term neglect have become appropriately looked after, opportunities have been missed to use this as a means of embedding learning and improving the quality of practice internally and across the partnership. The audits undertaken have not sufficiently identified the gaps in social workers knowledge around CSE risk assessment or missing from care protocols. The audits have failed to raise the profile of educational attainment and achievement and do not give sufficient weight to quality of social work practice, for example, the impact of historical concerns in cases. Some of the audits are overly optimistic and do not focus on the impact of experiences on the child and subsequently on how this may impact on decision making in cases.

153. Since April 2014, performance information is being provided at team manager level to strengthen operational oversight, but it is not yet having sufficient impact on improving the quality of social work practice. The local authority is not meeting its own targets in a number of areas. For example, timeliness of reviews, the number of re-referrals and the number of children being subject to child protection plans for a second and subsequent time. As corporate parents, the local authority has not been robust in improving performance in relation to children's attainment or for care leavers not in education, employment or training.

154. The workforce strategy (2014–15) and updated supervision policy are of good quality. There is a clear focus on safe workloads, effective supervision, continual professional development, training, and workforce planning, but this is not yet fully implemented in practice. Professional supervision is mostly regular, but the newly introduced templates are not being completed as intended to evidence reflective practice. There are missed opportunities to embed learning and raise the bar. Where performance or casework is discussed, this is focused on maintaining compliance as opposed to improving quality. There is insufficient focus on the impact of interventions or the progress of plans.

155. An improvement in the regularity of supervision and direction provided by managers can be seen in case records since April 2014. However, case supervision is not yet securing consistently robust challenge by operational managers, for example, where the quality of assessments and plans are weak. Where children are not receiving timely services to meet their needs, or where agencies disagree about decisions made, managers and IRO's are not escalating their concerns to a sufficiently senior level within children's services or the LSCB. The dispute resolution process has very recently (during the inspection) been reviewed, but has not yet been implemented.

156. Current training priorities and provision are linked to known areas for practice improvement and organisational needs. Training opportunities for staff are good and there is effective learning from serious case reviews. All service managers have completed NVQ level 5 qualifications in management, and team managers are currently undertaking accredited supervision and mentorship training. The multi-agency training panel, chaired by the Assistant Director for safeguarding, is providing a continuous focus on training needs and provision. However, training is not systematically monitored for its effectiveness on practice and this is not leading to a consistently good understanding of the impact of training both for individual social workers through supervision or by the organisation. Records of staff appraisal are sporadic and they do not consistently identify learning needs or address performance.

157. A refreshed caseload weighting system is currently being piloted and is improving manager responsiveness to social workers' caseloads. However, the point system is being inconsistently applied across the teams. Caseloads remain high in some teams; particularly some looked after children teams and the fostering team. This is reducing capacity to complete direct work with children and viability assessments in a timely way. The local authority has recently taken action to reduce high caseloads for IROs with the appointment of two additional officers, but this has not yet led to a consistently robust overview of cases between reviews nor contributed to improving the quality of social work practice.

158. Recruitment and retention rates of the social care workforce are generally good and there is a good offer of support for newly qualified social workers (NQSW's) and social workers in their first year of qualification (ASYE). There are well-established recruitment schemes such as 'grow your own' and 'step up to social work'.

159. There is a recent and renewed focus on the voice of the child across the service. The local authority actively ensures those children's voices are influential both strategically and operationally incorporated in the priorities of partners. Looked after children are contributing effectively to service delivery through the children in care council and Corporate Parenting Forum. The local authority has worked hard to ensure that looked after children can influence social work, though there has been insufficient focus on how children in need of help and protection can contribute to service development and improvement. A recently commissioned service from NYAS for children subject to child protection planning is now being offered where appropriate. This service is so recent that it is yet to impact on the participation of children at their meetings and child protection conferences, or to capture their voices to influence service planning.

160. There is a robust, accessible and well-evaluated complaints process for children, young people and their families. Positive action has been taken in response to concerns raised by looked after children, such as a review of the financial policy and staying put policy for care leavers. For children in need of help and protection, this is less well developed, and has only been available since April 2014.

Local Safeguarding Children Board (LSCB)

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

Summary of findings

The LSCB requires improvement because:

Child Sexual Exploitation

- The LSCB has not mapped and analysed intelligence around CSE in order to understand the scale, nature and patterns of sexual exploitation in its area and to use this to inform support, disruption, prevention and strategy.
- The LSCB does not exercise sufficient oversight of children missing from home, care or education (including children placed out of the local authority area).

Early help

- Progress around the development of Early Help is still at an early stage and more needs to be done to help workers understand the thresholds for access to children's services and facilitate viable inter-agency lower level services. The Board's scrutiny and challenge to partners around the application of thresholds and use of escalation needs to be stronger.
- The LSCB has not provided sufficient leadership or impact on addressing domestic abuse in its area, nor has it been effective in holding partners, particularly police, to account for the high number of domestic abuse notifications which are inappropriate.

Performance Management

- The data used by the Board are not sufficiently broad. Key multi-agency data is lacking and data is not used effectively to identify strategic need, inform business planning, or to hold agencies to account for performance. There has been insufficient focus on improving outcomes for children and young people and on challenging the quality of social work and multi-agency practice.
- The LSCB Business Plan does not have specific or measurable targets, and timescales for actions are unclear. The plan does not cover many of the Board's areas of responsibility.
- The Board is not sufficiently robust in scrutinising, challenging and tracking progress in key areas, such as reports about the work of the LADO.

Scrutiny and challenge

- A large number of safeguarding policies and procedures are out of date.
- The LSCB has not exercised sufficient oversight of public protection arrangements such as the MAPPA or MARAC.
- The LSCB's work on the voice of the child is not yet having an impact on children in need of help and protection
- The LSCB has not completed a training needs analysis, and has not exercised sufficient oversight of its training programme. Evaluation of training is still at an early stage.

What does the LSCB need to improve?

Priority and immediate action

161. Complete a profile and needs assessment of child sexual exploitation in the area and use this to drive disruption, prevention and victim support.

162. Ensure that the Board has robust oversight of children missing from home, care and education (including children placed out of the local authority area), using data and analysis effectively to reduce incidents of children going missing and placing themselves at risk.

163. Ensure that LSCB policies and procedures are up to date and meet statutory requirements and best practice.

164. Strengthen the challenge and focus on agencies playing an active role in the delivery of early help provision, and ensure that the threshold is understood and well embedded by partner agencies.

165. Scrutinise the sufficiency, effectiveness and coordination of partnership work in addressing domestic abuse.

Areas for improvement

Data and Performance

166. Develop a multi-agency data set and analysis that includes performance information from across the partnership, including police, health, education, housing, and data on missing children and CSE. This should include the educational attainment of the most vulnerable children. The LSCB should use data to understand strategic need, and to hold agencies to account.

167. Develop a multi-agency audit tool and programme to measure the quality of practice in early help, child in need and child protection.

Governance

168. Publish a Business Plan that covers all the key areas of its work.

169. Tighten the scrutiny of key reports, data and the recording and tracking of decisions and actions arising.

170. Strengthen the scrutiny of public protection arrangements in the MAPPA and MARAC.

Development of Key Areas

171. Strengthen work around hearing the voice of the child, with particular regard to children with a child protection plan and children in need. Ensure that creative methods are used to capture the voices of children with disabilities.

172. Ensure that the offer and take-up of training is reviewed in a timely way to ensure that the needs of the partnership are being appropriately met, and that training is evaluated effectively.

Inspection judgement about the LSCB

173. There are clear governance arrangements between the Director of Children Services, Chief Executive and the Independent LSCB Chair. The Chief Executive provides oversight of the work of the Board Chair and holds the Chair to account through a work plan which is reviewed regularly. This contains clear direction and timescales for actions. This rigour has been instrumental in driving recent improvements in the Board's performance from a previously low base. The LSCB has a constitution in place which sets out clear roles and responsibilities in line with statutory guidance.

174. The Board is appropriately constituted with the right statutory agencies and membership at the appropriate level of seniority to represent their agencies and commit resources. The LSCB also has three Lay Members who play an active role.

175. The LSCB has robust links with other strategic bodies. It has strong and established links with the Health and Wellbeing Board, the Community Safety Partnership and the local Criminal Justice Board; respective chairs meet quarterly to monitor progress against set priorities. It has recently engaged with the Criminal Justice Board to improve court consideration of children's safeguarding when making bail conditions for offenders, following the learning from a Serious Case Review (SCR). The Board also has active links with the Family Justice Board through the Chair and legal advisor, which enables it to oversee issues arising in public and private proceedings. This has led to the Board challenging delay in issuing post-proceedings letters, the management of child mental health issues in public and private proceedings, and a protocol to ensure that young people are not bailed to police cells.

176. The Board has not had sufficient oversight of the work of MAPPA and the MARAC. This means that it has not scrutinised the public protection arrangements around the management of dangerous offenders and cannot therefore be confident of the effectiveness and impact of these arrangements

177. The LSCB is a strong and effective body in influencing the priority setting and commissioning arrangements of the Health and Wellbeing Board. A Memorandum of Understanding to clarify governance between the two Boards is in place. As a result of Board challenge, the Health and Wellbeing Board has included the voice of the child in its commissioning arrangements. This resulted in over 4,000 children contributing feedback to the Joint Strategic Needs Assessment (JSNA), which has been used to inform a number of significant service improvements in health commissioning for young people, such as a tier two substance misuse worker being commissioned to work in schools.

178. Through the LSCB's influence, the Health and Wellbeing Board included CSE in the JSNA and has recently re-commissioned arrangements for tier two CAMHS provision. This initiative was undertaken as a result of a LSCB learning review which concerned a young person who had attempted suicide, and LSCB data which indicated that St Helens has a high rate of teenage self-harm. This has improved access to help for young people with mental health problems and could potentially reduce incidents of suicide and self-harm.

179. The LSCB has also drawn learning from its partnership reviews, multi-agency audit and its consideration of data, to identify the need to challenge and develop better early help arrangements across the partnership. This includes recently publishing the Continuum of Need document, which realigns early help provision. However, this is at an early stage of implementation and there continue to be difficulties engaging some universal services partners in the delivery of the early help framework. This has been recognised by the Board, who have included the review of this gap in the work plan going forward, together with consideration of the need for further commissioning but the pace of this work needs to increase.

180. The Continuum of Need and Early Help arrangements are not yet making a difference to high referral and re-referral rates to Children's Social Care, and more needs to be done to hold partners to account and ensure that they understand and more consistently apply agreed thresholds.

181. The Board is facilitating multi-agency sign-up to the MASH, but this is still at an early stage and more work is needed to ensure health participation in the arrangements.

182. The LSCB has not demonstrated leadership, challenge or scrutiny around the gaps and needs in partnership work on domestic abuse. The Community Safety Partnership has led the work on domestic abuse locally, but their focus has been on adults, and a strategy for children has not yet been developed. The LSCB has not taken a strong enough lead in challenging and scrutinising the effectiveness of partnership work despite the fact that this is a key priority for the Board. For example, policies and procedures are underdeveloped, and domestic abuse is not well integrated in the Continuum of Need. The Board has not scrutinised commissioned arrangements, audited practice or developed an effective data set to monitor performance. These issues have not been adequately addressed in the Business Plan.

183. Support services for adult victims do not yet sufficiently consider the needs of children; there is little or no preventative work in the community, in schools and with parents around the harm caused by domestic abuse. The professional network is not yet sufficiently trained to work with victims, perpetrators and their children, and there are gaps in early help provision and pathways around domestic abuse. Professionals have no risk assessment tool for working with domestic abuse, nor developed protocols and procedures, and there is very limited resource available for direct work with the children in these situations.

184. The LSCB has very recently driven the implementation of Operation Encompass, which is improving communication and coordination between schools and the police about domestic violence incidents. When a domestic incident occurs, police immediately notify the child's school, which ensures that a designated member of staff makes contact with the child to assess the level of support required.

185. The LSCB receives a limited range of multi-agency data which it analyses and has very recently used to inform its priorities and planning. However, the Board needs to improve the use, range and analysis of multi-agency data to strengthen its strategic understanding of local need and to hold partners to account more effectively. The current data set does not have enough data from the police, education, health, and housing; nor does it include recruitment, retention and caseload rates of partners. It does not include data around children missing from home, care or education or those at risk of child sexual exploitation. The educational attainment of children subject to child protection plans or child in need plans is not reviewed.

186. The LSCB Annual Report for this year has been delayed and missed the start of the local commissioning budget and planning cycles. It has only just been signed off by partners.

187. The Annual Report meets statutory requirements and provides an evaluation of safeguarding in the area; it sets out appropriate priorities drawn from data and has a work plan to tackle these. However, the analysis within the report is limited because the data available to the Board is overly focused on social care performance and does not sufficiently evaluate that of the wider partnership. The Board has an understanding of the underlying reasons for the trends in the data it has considered, but this is still at an early stage and further work is required.

188. The LSCB has very recently signed off a new set of appropriate priorities which have been drawn from an analysis of local need, the JSNA and data. The new priorities have been used to drive the Business Plan, which appropriately focuses on the most vulnerable children: those at risk from neglect, domestic abuse, substance misuse, mental health, and CSE. Although the priorities have only been signed off recently, they have been informing much of the planning over the past twelve months, and have led to improvements in re-commissioning early help arrangements, the use of the graded care profile, tier two CAMHS support, Operation Encompass for child victims of domestic abuse, Catch 22 service for missing children, a dedicated CSE unit in the MASH and a new quality assurance post in the LSCB to strengthen its scrutiny. However, whilst the new Business Plan is ambitious in its scope and vision, it is insufficiently clear about how its priorities will be delivered. The Business Plan does not comprehensively address all the areas that the LSCB is required to scrutinise or coordinate. It is a development plan around the key priorities, but this means that the Board does not have a suitable plan for the rest of its business.

189. The LSCB carries out a range of effective multi-agency audits of practice which have led to some strong examples of impact and improved outcomes for children. For example, the LSCB reviewed arrangements for children who were electively home educated, some of whom had not been visited for two years. As a result of this work the local authority ensured that every such child was visited and a new protocol was implemented to strengthen the safeguarding and educational oversight of these children; following this, a number of children re-entered mainstream education. In addition, the multi-agency review of neglect led to the introduction of the graded care profile to help agencies identify and escalate neglect better. The implementation of this model is very recent and is yet to demonstrate impact on the number of children suffering neglect, but has the potential to be a positive development.

190. The audit also raised the importance of improving the early help offer and reducing the rate of re-referrals, and it informed the work plan around the realignment of the statutory social work teams and the Continuum of Need. Further work is now needed to review the impact of this and to develop a neglect strategy for the partnership, which is now the Board's top priority. The Board also undertook a rigorous review of the restraint of children in a local residential unit following a high number of incidents leading to hospital attendance. The review challenged practice in the home, as a result of which there has been staff training, tighter procedures and a reduction of incidents.

191. Whilst the Board's multi-agency audit programme has some strong examples of impact and effectiveness it has only been partially aligned with its new priorities. The Board has recognised the need for greater focus on core business and has recently set out a new timetable of multi-agency audit to include children on child protection plans and children in need and early help, and has procured additional resource to deliver this.

192. Whilst the Board can evidence some strong examples of challenge and scrutiny of some partners, this is inconsistent and follow up often lacks rigour. For example the LSCB Board meeting did not scrutinise the LADO, Private Fostering or the IRO annual reports. The Board noted the reports for information, but did not properly examine them, nor identify relevant issues within the Annual Report. Similarly, discrepancies identified in data did not lead to robust action to check why some parents on the MARAC were not known to social care.

193. Board minutes are of poor quality, do not record decisions and actions clearly nor show that these have been followed up at subsequent meetings. The local authority has undertaken a recent audit of LSCB processes at the request of the CEO. The outcome of the audit findings were not available for inspectors to evaluate.

194. The Board delivers a wide range of multi-agency training to the partnership and has offered places to 2,000 members of staff. This is informed by the priorities, learning from SCRs, and emerging needs analysis. Almost all GPs have now received bespoke level 3 safeguarding training. Training is valued by practitioners and they report that it is influencing their practice, with tangible examples given of cases being escalated to strategy meetings as a result of training, or improved responses to children subject to CSE or at risk of Female Genital Mutilation.

195. The training programme is, however, not based on a comprehensive analysis of need in the partnership and there are some gaps, for example, working with adult mental health and disabled children. The LSCB has also not had a report for last year's training activity nor the training offer for this year. This means that the Board's ability to review the suitability of the training offer and the multi-agency take-up of training is limited.

196. Although attempts to evaluate training are at an early stage, the Board can provide some strong examples of impact on practice, but this is still anecdotal and reliant on practitioner self-report. Independent feedback from managers is not yet being used to evaluate the impact of training on practice.

197. A large number of the policies and procedures of the LSCB are out of date and do not reflect recent guidance or best practice, nor do they integrate the new thresholds and pathways around Early Help. This includes the procedures around missing episodes, child sexual exploitation and domestic violence. This means practitioners across the partnership do not have an up-to-date resource to assist them assess levels of risk and need, which potentially leaves children and young people at risk and contributes to the volume of inappropriate referrals to children's social care.

198. The LSCB has a comprehensive multi-agency plan to respond to and prevent CSE. However, this is yet to be translated into up-to-date procedures which reflect the level of activity and referral pathways. The LSCB has carried out some awareness raising within schools and in businesses, and has trained over 70 members of staff. A Multi-Agency Child Sexual Exploitation (MACSE) panel has been set up to review all children believed to be victims of CSE in the area and coordinate an appropriate response. The police have resourced a unit within the MASH to work with children who are victims of sexual exploitation. As a result of the LSCB work plan, in June 2014 Catch 22 were commissioned to undertake return interviews of children who go missing from home or care and provide direct work with those who are being sexually exploited. However, this strategy is still in its early stages and the Board has not yet completed a problem profile to identify the extent of child sexual exploitation in its area and links with neighbouring local authorities. This means that the LSCB does not have a good understanding of the extent or nature of child sexual exploitation in its area.

199. The LSCB has not received a data set around children missing which meets statutory requirements. A new data set has been developed by Catch 22, who were commissioned through the LSCB to deliver return interviews and direct work to children who go missing for the first quarter of 2014–15. This has been seen by inspectors and will meet statutory requirements going forward. However, it does not capture data on those children placed out of the local authority area who go missing. The LSCB's oversight of children missing from education is not currently robust and needs to improve.

200. Serious Case Reviews are completed in line with statutory guidance. Two SCRs are currently in progress. Ofsted has been notified appropriately in accordance with statutory requirements. Learning from a SCR published earlier this year has been used effectively to improve practitioner awareness and to drive training and service improvements across the partnership. The impact of learning is tracked rigorously by the Chair of the Critical Incident Panel. A local learning and improvement framework is in place. There is training provided to staff around the lessons. Most of the staff that inspectors spoke to said that they had attended SCR training, and they were able to articulate some of the learning from local and national reviews and relate it to their practice.

201. The LSCB has led a range of work to safeguard children from bullying and promote E-Safety within schools; this has reached over 4,000 pupils in anti-bullying initiatives. Around 400 children and young people have been trained as anti-bullying ambassadors in schools. The Board ran an E-Safety conference with young people, and produced a pack for foster carers in collaboration with young people in care.

202. There has been an impressive array of work to embed the Voice of the Child within wider health commissioning arrangements and other universal services. As a result of feedback from children, a tier two drugs and alcohol worker has been commissioned to work in schools, self-harm has become a higher priority for the local authority Scrutiny Committee, a housing provider, the women's refuge and the Troubled Families Team who are all working to integrate the voice of children more closely into their work. Agencies have reported back to the Board about how children's voices have been heard and acted upon.

203. About 300 members of social care staff have received training this year around hearing the voice of the child, and the National Youth Advocacy Service (NYAS) has been recently been commissioned to provide advocacy to young people in child protection conferences. A further round of training is planned for 2015. Inspectors did not see any advocates at the child protection conferences that they observed and are therefore unable to judge the impact of this work. Whilst the Board has been consulting young people about the best way to do this, the voice of the child is not yet effectively represented at Board level.

204. The LSCB has an effective Section 11 process that holds agency partners to account for safeguarding. The audit was last carried out in 2013 with statutory agencies, looking in detail at all areas set out under section 11 legislation. A multi-agency panel met to scrutinise senior officers closely over the evidence base of their audit and progress made since the last audit. A detailed report was produced for the Board on the strengths and weaknesses of each agency, and they were charged with taking development points forward. The panel were assured that each of the agencies met the criteria for governance and that safeguarding was prioritised appropriately in each of the organisations. The audit highlighted issues around E-Safety; incorporating the voice of the child in both service design and delivery, including in child protection conferences; and raising community awareness of CSE. These have been taken forward by the work of subgroups.

205. The financial foundations of the Board are sound and resources are shared proportionally between partners.

206. The Child Death Overview Panel is shared with four other local authorities in Greater Merseyside. It is well attended and functions well. It provides an effective analysis of child deaths in the region, which is broken down by local authority so that they can understand local as well as regional data. The Panel tracks issues back to partner agencies rigorously for follow up where modifiable factors are identified. Although the Panel and its partners have not run a large scale public health campaign for some time, one is being planned for next year, once the Panel has completed an analysis of the trends and patterns of all child deaths since 2008.

What the inspection judgements mean

The local authority

An **outstanding** local authority leads highly effective services that contribute to significantly improved outcomes for children and young people who need help and protection and care. Their progress exceeds expectations and is sustained over time.

A **good** local authority leads effective services that help, protect and care for children and young people and those who are looked after and care leavers have their welfare safeguarded and promoted.

In a local authority that **requires improvement**, there are no widespread or serious failures that create or leave children being harmed or at risk of harm. The welfare of looked after children is safeguarded and promoted. Minimum requirements are in place, however, the authority is not yet delivering good protection, help and care for children, young people and families.

A local authority that is **inadequate** is providing services where there are widespread or serious failures that create or leave children being harmed or at risk of harm or result in children looked after or care leavers not having their welfare safeguarded and promoted.

The LSCB

An **outstanding** LSCB is highly influential in improving the care and protection of children. Their evaluation of performance is exceptional and helps the local authority and its partners to understand the difference that services make and where they need to improve. The LSCB creates and fosters an effective learning culture.

An LSCB that is **good** coordinates the activity of statutory partners and monitors the effectiveness of local arrangements. Multi-agency training in the protection and care of children is effective and evaluated regularly for impact. The LSCB provides robust and rigorous evaluation and analysis of local performance that identifies areas for improvement and influences the planning and delivery of high-quality services.

An LSCB **requires improvement** if it does not yet demonstrate the characteristics of good.

An LSCB that is **inadequate** does not demonstrate that it has effective arrangements in place and the required skills to discharge its statutory functions. It does not understand the experiences of children and young people locally and fails to identify where improvements can be made.

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 works 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 8 of Her Majesty's Inspectors (HMI) from Ofsted.

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