Knowsley 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: 29 April – 21 May 2014

Report published: 30 June 2014

The overall judgement is **inadequate**

There are widespread or serious failures that create or leave children being harmed or at risk of harm.

It is Ofsted's expectation that, as a minimum, all children and young people receive good help, care and protection.

1. Children who need help and protection		**Inadequate**
2. Children looked after and achieving permanence		**Requires improvement**
	2.1 Adoption performance	**Inadequate**
	2.2 Experiences and progress of care leavers	**Requires improvement**
3. Leadership, management and governance		**Inadequate**

The effectiveness of the Local Safeguarding Children Board (LSCB) is **inadequate**

The LSCB is not demonstrating that it has effective arrangements in place and the required skills to discharge its statutory duties.

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

Contents

Section 1: the local authority

Summary of key findings

This local authority has serious weaknesses and is not yet good because

1. Widespread failures and inconsistent practice across help and protection services leave some children and young people at risk of suffering harm. Too many children and young people who need help and support or who need to be cared for by the local authority experience drift and delay. Some have been left for too long in situations where they have suffered harm.

2. Early help services are not well coordinated or targeted, therefore the local authority cannot be sure that children and young people who most need support get it or that early intervention is preventing the need for statutory involvement. Although increasing, the number of common assessments (CAF) undertaken remains low and the quality is poor overall, so that in many cases children's needs are not recognised or addressed early enough.

3. The threshold for referral to children's social care is not consistently applied by partner agencies and children's services. A significant number of cases are inappropriately assessed prior to being stepped down to a CAF due to not meeting the threshold for a social work service.

4. Assessments undertaken by social workers do not consistently consider all risks to children and young people. Children and young people in need of help and protection are not always seen alone as part of their assessments. Their voices are not heard and their experiences are not fully understood. Social workers place too much focus on the needs of adults.

5. While strategy discussions are held promptly, they do not always involve the minimum representation of agencies required by Working Together. The social workers who carry out child protection enquiries are not usually involved in the strategy discussion and don't share in the valuable initial exchange of information that helps to decide the action needed.

6. Plans to protect children are often not clear or outcome focused. This has resulted in drawn out ineffective engagement with families which has not achieved the desired improvements. Too many child protection plans are ended before real long term change is achieved, with children needing a further protection plan to secure their safety. Reviews are not sufficiently effective in challenging the lack of progress.

7. The quality of record keeping is variable and often poor across all the social work teams with, for example, little use of chronologies to gain understanding of historical factors that may be significant in assessment of risk. Recording in many children's files is not up to date.

8. There are significant weaknesses in management oversight with a legacy of infrequent and poor supervision of social work staff, particularly in the safeguarding and assessment teams. While there has been a very recent improvement through ensuring that all staff have regular supervision, the quality remains low. These weaknesses have contributed to the lack of progress in plans.

9. A high turnover of social workers in the assessment and safeguarding teams has resulted in too many children being unable to develop effective relationships with their social workers. This contrasts with the experience of children in the looked after children's team, many of whom form good relationships with their social workers.

10. Once they become looked after, some children continue to experience delay and drift through a lack of robust care planning and review; some also wait too long before permanence plans are made. The quality of care plans is poor and insufficient challenge is provided by independent reviewing officers. The quality of pathway plans for care leavers is inconsistent, with some lacking clarity about young people's needs.

11. It takes too long from when a child first becomes looked after to becoming adopted when this is in the child's best interest.

12. The local authority does not have a robust strategy to ensure that sufficient suitable placements are available to meet the needs of all children looked after in Knowsley. Not all children looked after benefit from stable placements that meet all their needs. Performance on stability has declined in the past year and is poorer than comparators.

13. The educational progress of children looked after varies between year groups. Children make good progress in the early years and across Key Stage 2. However, in secondary schools the level of progress falls significantly. Outcomes at Key Stage 4 are not good enough and the gap between children looked after and their peers in Knowsley is too large.

14. For children looked after in placements outside Knowsley, the virtual school does not hold information from all education providers. This makes it difficult to monitor the progress these children are making, to challenge the effectiveness of the provision, or to know whether additional support is needed.

15. Knowsley Council does not currently collect and analyse data systematically to help plan service developments, for example the needs of children becoming looked after do not inform fostering recruitment.

16. Young people's records do not evidence whether they have been provided with information about their entitlements, how to complain or how to access advocacy services. The electronic information system does not support good planning or provide good quality management information.

17. Although there have been some recent improvements, performance management is under-developed and there is no established quality assurance system. This makes it difficult for all managers to monitor the quality of social work practice or the progress of actions designed to improve it.

The local authority has the following strengths

18. The recently appointed senior management team are aware of a number of significant deficits in the provision of services to children and families. An improvement plan has been drawn up and some remedial action has already started. This includes a plan for more effective access to early help and a re-design of fieldwork services to address too many children experiencing poor outcomes.

19. Senior managers are now more visible to, and more supportive of, frontline social workers. Social workers are positive about the recent changes.

20. Some good individual services offer high quality early help and prevention, such as Families First, Stronger Families, Encompass, the Freedom Project and services for families and children with disabilities.

21. There have been sustained improvements in the timeliness of care proceedings through the courts.

22. Children looked after in Knowsley benefit from regular health, dental and optical assessments, including assessment of their emotional well-being.

23. When children transfer to the looked after children's team they benefit from stable relationships with their social workers. These children are listened to and their wishes and feelings are explored and recorded. Many are positive about their placement and the relationships they have with their carers.

24. For children who go missing from care, missing from education or are at risk of child sexual exploitation, there are established systems to ensure their wishes and feelings are considered when they return.

25. 'Making a difference everywhere' groups comprising representatives of children looked after in Knowsley perform a valuable role including collecting and representing the views of children and young people to inform service delivery.

26. Care leavers in Knowsley are well supported, live in suitable accommodation and are accessing education, training and employment.

What does the local authority need to improve?

Priority and immediate action

27. Ensure that professionals in all partner agencies and social care understand and apply the threshold for referral to children's social care.

28. Implement a quality assurance framework across children's services, including the regular auditing of case records, personal education plans and CAFs.

29. Ensure that staff supervision is regular and that supervision practice is audited with a focus on the quality of supervision offered. Deliver training for managers to support the development of supervision in line with the supervision policy.

30. Review support for newly qualified staff and ensure that there is sufficient senior management oversight of the experiences of these staff.

31. Ensure that strategy meetings involve representatives from at least three agencies and include the workers who will carry out any enquiries, and ensure that the minutes of the meeting include clear directions and rationale for actions. Ensure the outcomes of child protection enquiries are always shared with the key professionals involved with the child and family.

32. Ensure that statutory visits to children and young people on child protection plans are regular and carried out by suitably experienced social workers, that children are seen alone and that records include their views.

33. Ensure that core groups are held regularly and that agencies involved with the family routinely attend in order that information is fully shared and plans are understood and carried out promptly.

34. Ensure that robust permanency plans are in place for all children looked after at the earliest point. This should include improving matching processes for children who need long term placements to ensure their needs are being met and their outcomes secured.

35. Implement the care planning tracker to ensure that plans for children looked after are timely and those children with an adoption plan are adopted without avoidable delay.

Areas for improvement

36. Improve the take-up of common assessments (CAF) by partner agencies and improve the quality of CAFs completed so they are an effective system for coordinating early help to families who need this.

37. Evaluate the effectiveness of early help services, and in particular check that help is delivered to those who most need it, and evaluate the extent to which early help prevents the need for more intensive intervention.

38. Improve the quality of assessments, in particular ensure that they take full account of historical factors and that strengths and risks are fully considered. Ensure that children and young people are always seen alone and spoken to as part of the assessment process.

39. Improve the quality of plans, in particular ensure that they are specific, measurable, have timescales, and are written clearly in order that all involved understand what they need to do.

40. Ensure that professionals invited to child protection conferences consistently provide written reports so that all risks are considered and appropriate decisions and plans can be made.

41. Ensure that social work reports for child protection conferences include an up-to-date assessment of risk, and are shared with the family before the day of the conference.

42. Improve scrutiny and challenge by child protection conference chairs and independent reviewing officers, in particular in cases where there has been or there is risk of drift and delay in plans being progressed.

43. Deliver training on child sexual exploitation to all relevant staff, in particular those in front line social work teams.

44. Ensure that social workers have the skills and tools to support effective direct work with children.

45. Ensure that recruitment of foster carers and the number of residential placements are responsive to the needs of the current and future children looked after population from Knowsley.

46. Improve the educational achievement of children looked after by monitoring pupil progress against clear targets in personal education plans. For all children looked after who receive education outside the borough, ensure that sufficient information is received to evaluate their progress and ensure their outcomes are improving.

47. Improve the quality of pathway plans so that they provide a clear assessment and analysis of young people's aspirations to support their plan for a successful transition into adulthood.

48. Ensure that all children looked after and care leavers are provided with information about their entitlements, how to complain and how to access the advocacy service. Ensure that this is clearly recorded.

49. Improve the current electronic information system to support good quality assessment and planning and provide useful management information reports.

50. Ensure that the children's charter is re-enforced with clear statements of what children and young people in care in Knowsley can expect from their social workers, senior managers and politicians and partners who provide services to young people in care.

51. Review the joint strategic needs assessment (JSNA) and the strategic needs assessment particularly in relation to the experiences of vulnerable children, and re-align priorities and areas for development as a result.

52. Ensure that social care is represented on all key planning forums such as the Health and Wellbeing Board.

Information about this inspection

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people who it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

Ofsted produces this report of the inspection of local authority functions and the review of the local safeguarding children board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

The inspection team consisted of five of Her Majesty's Inspectors (HMI) from Ofsted, one contracted inspector and one additional inspector.

The inspection team

Lead inspector: Robert Hackeson

Team inspectors: Peter McEntee, Tracey Metcalfe, Jansy Kelly, Kathryn Gethin, Nancy Meehan and Ralph Trevelyan-Butler.

Information about this local authority area[2]

Children living in this area

- Approximately 32,788 children and young people under the age of 18 years live in Knowsley. This is 22% of the total population in the area.
- Approximately 31% of the local authority's children are living in poverty (the national average is 20%).
- The proportion of children entitled to free school meals:
  - in primary schools is 29.4% (the national average is 18.1%)
  - in secondary schools is 34.1% (the national average is 15.1%).
- Children and young people from minority ethnic groups account for 4.5% of all children living in the area, compared with 21.5% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are mixed ethnic background and Asian or Asian British.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 2.1% (the national average is 18.1%)
  - in secondary schools is 0.6% (the national average is 13.6%).

Child protection in this area

- At 31 March 2014, 1,118 children had been identified through assessment as being formally in need of a specialist children's service. This is a 9.6% reduction from 1,237 at 31 March 2013.
- At 31 March 2014, 195 children and young people were the subject of a child protection plan. This is a 36.4% increase from 143 at 31 March 2013.
- At 31 March 2014, one child lived in a privately arranged fostering placement. This is an increase from zero at 31 March 2013.

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

Children looked after in this area

- At 31 March 2014, 262 children are being looked after by the local authority (a rate of 78.7 per 10,000 children). This is a 10.5% increase from 237 (73.1 per 10,000 children) at 31 March 2013. Of this number:
  - 129 (or 49.2%) live outside the local authority area
  - 27 live in residential children's homes, of whom 70.0% live out of the local authority area
  - 2 live in residential special schools, and live out of the authority area
  - 194 live with foster families, of whom 44.8% live out of the authority area
  - 21 live with parents, of whom 38.1% live out of the authority area
  - No children are unaccompanied asylum-seeking children.
- In the last 12 months there have been:
  - 10 adoptions
  - 15 children who became subjects of special guardianship orders
  - 92 children have ceased to be looked after, of whom 7.6% subsequently returned to be looked after
  - 11 children and young people have ceased to be looked after and moved on to independent living
  - There are no children and young people who have ceased to be looked after and are now living in houses of multiple occupation.

Other Ofsted inspections

- The local authority operates four group children centres. Three have recently been inspected. Two were judged as good and one outstanding by Ofsted.
- The local authority operates four children's homes, all of which were judged as good in their last full inspection. In their most recent interim Ofsted inspection three were judged to be making good progress and the fourth was judged to be making satisfactory progress.
- The previous inspection of Knowsley's safeguarding arrangements was in March 2010. The local authority was judged to be good.
- The previous inspection of Knowsley's services for looked after children was in March 2010. The local authority was judged to be good.

Other information about this area

- The Director of People's Services took up post on 1 October 2013.
- The chair of the LSCB has been in post since September 2012.

Inspection judgements about the local authority

The experiences and progress of children who need help and protection are inadequate

53. Children and young people in Knowsley do not consistently get the services they need at the time they need them to ensure that they are supported and protected. This includes those who need early help through to those children who are recognised as in need of protection and are subject to a child protection plan. There are significant weaknesses in the core areas of social work practice including management oversight, assessment and child protection. This leaves children and young people at risk of harm.

54. The local authority is aware of these weaknesses, and has developed an improvement plan. Recently appointed senior managers know what they need to do to improve the quality of practice and services for children and young people in Knowsley. However, remedial action is still at an early stage and significant impact is not yet evident in day to day practice.

55. Children and their families have access to a good range of universally available early help services. Three of the four children's centres in Knowsley have been judged good or outstanding by Ofsted. Parents have told inspectors support from 'Stronger Families' (Knowsley's troubled families programme) has improved their self-esteem and confidence and their ability to communicate with their children. Although some children benefit from early help, services are not well coordinated or targeted, so not all children and young people receive the support they need. The local authority currently does not evaluate the range of support on offer nor does it ensure it is successfully targeting the greatest need.

56. Take-up of the common assessment framework is increasing but remains low, particularly for children under school age, due to low completion rates by partners, especially community health Schools report that many children are entering education without their needs having been fully addressed, and this then affects their readiness to learn. CAFs completed are often of poor quality and in many cases are used as a substitute for a referral for other services rather than as a tool for the lead professional to coordinate a package of support

57. Thresholds for intervention are not consistently applied by all partners. A significant number of referrals to social care which proceed to an assessment then result in step down to a CAF. This means many children and their families are being escalated into statutory services inappropriately without the opportunity for timely early help and support. The local authority plans to re-launch the early help strategy in September 2014 and refresh the current threshold document.

58. In March 2014, the local authority and partners introduced a multi-agency safeguarding hub (MASH) and the local authority is in the process of closing down the Knowsley Assess Team (KAT) which currently receives contacts and sends them to the MASH. Early evaluation of the MASH shows it is leading to more effective information sharing by partners to identify children in need of help and protection quickly and provide a single point of entry to children's social care. The current process whereby the KAT receives and passes on contacts results in a substantial number of inappropriate contacts being sent to the MASH, which diverts social workers from safeguarding activity into signposting children and families to early help. Permission to undertake enquiries is sort by social workers when appropriate.

59. Children and young people who require protection are appropriately identified by the MASH and strategy discussions are held promptly where appropriate, although they do not always involve the minimum representation of agencies required by Working Together. Strategy discussions observed at the MASH considered risks well. However, the written records did not always demonstrate that risks had been explored sufficiently or provide a clear direction and rationale for actions. This is particularly important because the social workers who carry out child protection enquiries are not based in the MASH and are unlikely to have attended the strategy meeting. This means that key information is not always readily available to professionals when determining risks to children, nor is it always clear how the investigation should be conducted or by whom.

60. Not all child protection enquiries are led by suitably experienced social workers and too many are conducted by social care as a single agency. Management oversight of the quality of the enquires is limited and the outcome of enquiries is not always recorded or shared with key professionals involved with the child. This means that not all enquiries are robustly considered or supported by agency partners.

61. The high turnover of social workers in assessment and safeguarding teams has resulted in too many children being unable to develop effective relationships with their social workers, and parents having to tell their history to new workers on a number of occasions.

62. Too many children have been left for too long in situations where they have suffered harm. Knowsley has taken positive action in recent months to tackle the lack of purposeful planning in certain teams. This is beginning to identify previously unmet needs. There has been a rapid and appropriate rise in the number of children subject to child protection plans in the borough from 119 in October 2013 to 195 in March 2014 as this action begins to have impact.

63. The authority cannot yet be sure that all children who need protection get the service they require. There has been insufficient consideration and understanding of risk in a number of assessments, leading to services not intervening when they should. Children's needs arising from their ethnicity and

culture are not sufficiently explored or addressed. Children are not seen routinely as part of assessments and there were few examples of direct work with children. This means children's voices are not heard and are not the focus of social workers' interventions.

64. Recording in many children's files is not up to date. It is difficult to see what actions have taken place to safeguard children and how decisions are made. Chronologies are not used to support assessments and enable social workers to recognise the cumulative impact of abuse on children, including the impact of neglect. There is little evidence that the impact of domestic abuse, adult substance misuse and parental mental health are understood in terms of the emotional impact on children in the short- and long-term. There is an over reliance on parental self-reporting and insufficient consultation with other agencies to verify parents' accounts. These omissions were seen across teams and affected several points in the child's journey where managers have not provided sufficient levels of supervision and challenge.

65. Overall, children's plans are not sufficiently outcome focused. The format of child protection plans does not support social workers to focus on risk. Plans often do not contain parents' or children's views and are difficult to read. Too many child protection plans do not identify key risks to enable parents and professionals to be clear about what needs to change and within what timescale, or the consequences if things do not improve. This results in statutory visits to children lacking a clear purpose or being capable of measuring progress.

66. Variable attendance and participation by professionals at child protection conferences means they do not all contribute to important discussions and information sharing needed to keep children safe. Agencies do not consistently provide written reports or share reports with parents. Parents often hear information for the first time at the conference and this makes their participation difficult.

67. Social work reports to review conferences are not supported by recent assessments, do not have chronologies and many lack sufficient analysis. This affects the quality of decision making and results in the full extent of progress or risks to children not being fully understood. Children and young people are not routinely invited to their conference. One young person told inspectors she did not understand why she had a protection plan as her social worker had changed three times and she had never got to know any of them. In many cases there was no evidence of direct work with children to promote their participation in the child protection process. There was a lack of awareness among social workers of the availability of the advocacy service to assist in this regard.

68. Visits to children on protection plans are at times carried out by inexperienced social workers and children are not always seen alone.. Little direct work is carried out with children to ascertain their wishes and feelings. Not all core

groups are held within appropriate timescales and not all agencies routinely attend, which means information is not shared effectively with key professionals to measure progress in the protection plan or evaluate the effectiveness of support.

69. Single assessments are not updated following the initial conference. When decisions are made to remove a child from a protection plan, professionals do not have the benefit of current and relevant assessments offering sufficient evidence of parents' capacity to achieve and sustain change. Over the past year a quarter of children made subject to a protection plan had previously been on a plan which is significantly above the rate for comparators.

70. There is a lack of scrutiny and challenge by conference chairs who have not had sufficient impact on improving outcomes for children and young people. Insufficient challenge has contributed to further drift and delay in plans being progressed. The Independent Reviewing Officers (IRO's) in Knowsley also act as independent chairs for child protection case conferences. However, the IRO Service Annual Report 2014 does not provide any information on child protection practice and performance to senior managers.. This means that senior managers do not have access to valuable information to assist their understanding of the quality of practice or the effectiveness of child protection processes to safeguard children and improve their outcomes.

71. For children living in households where there is a high risk of domestic violence, multi-agency risk assessment conferences (MARAC) are effective, with good representation and input from partner agencies. The 'Encompass' programme provides information to schools in the borough within 24 hours when pupils have been exposed to domestic violence, so that support can be arranged if needed. Substance misuse services provide an integrated service for young people and adults. They work closely with children's social care to identify children living with parents or carers who misuse substances and they help to provide early identification of children at risk of misusing substances. However, not all social workers recognise in their assessments the full potential risks to children that domestic violence or substance misuse may cause.

72. Arrangements for identifying and tracking children and young people missing from education are effective, with good action taken to reduce the number, from 65 in 2013 to three in the current academic year. Children who go missing from care have a return home interview conducted by their allocated social worker. The system does not, however, collate and analyse data or link it to the child sexual exploitation (CSE) data. This represents a missed opportunity to provide support through early help and to identify patterns and trends where children and young people may be at risk.

73. Systems to support agencies to identify children and young people at risk of sexual exploitation are in place. The development of the multi-agency child sexual exploitation (MACSE) sub-group is well coordinated by the police and provides an effective multi-agency forum for identifying and tracking potential

victims of child sexual exploitation and perpetrators. There are good practice examples of work with universal services to raise awareness through training. However, this training has not been extended across children's social care to front line social work teams where risk assessments are undertaken. Practice guidance for social workers in relation to CSE has not been implemented and not all social workers know what action to take as a consequence. This is a significant gap. The local authority together with the police plan to launch the guidance in June 2014.

74. The out-of-hours service offers a good level of support to children and families. In cases seen, the service offered a robust and well-coordinated out-of-hours response and maintained good communications with daytime services, so that information about children was shared effectively.

75. A strategy is in place to raise awareness across agencies and the community, and the procedures to ensure the safety of children living in private fostering arrangements are appropriate. Nevertheless the number of children known to be in private fostering arrangements is very low, which raises the concern that some children are not recognised and supported when they are living apart from their immediate family.

76. Allegations against adults who work or volunteer with children are taken seriously. Effective tracking and information sharing processes are in place with partner agencies and neighbouring authorities. There is good communication between the Local Authority Designated Officer (LADO) and children's social work teams to generate referrals where children may be at risk of harm. The local authority recognises the need to raise the profile of the LADO role among partner agencies and the voluntary sector and within its own services.

77. Most child protection investigations involving children with a disability are co-worked with an experienced worker from the disabled children's team ensuring children's individuality and needs arising from their disability are understood. Social workers in the disabled children's team do not have specific training or qualifications in communicating with disabled children despite many having worked there for many years. This means these children are not listened to or heard as well as they could be independently of their parents or carers.

78. Parents of disabled children have a strong voice in relation to the development of services and support for their children and the community. This is not replicated in children in need or child protection services. Overall there is little evidence that practice is informed by feedback from children, young people and their families.

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

79. The local authority is working to tackle the legacy of poor permanence planning for children who become looked after. This is having some success but as yet not all children and young people have a permanence plan in place quickly enough.

80. Poor practice in assessment and planning for children in need has led to some children and young people becoming looked after later than would be in their best interests. This is recognised by the local authority and since December 2013 targeted work has been undertaken to ensure that children become looked after when it is right for them. This has led to an appropriate rise in the number of children becoming looked after.

81. When children transfer to the looked after children's team they benefit from stable relationships with their social workers. These children and young people are listened to and their wishes and feelings are explored and recorded.

82. When children need to be protected by a court order the local authority has been effective in reducing timescales for care proceedings to within the 26 week deadline. Knowsley now has in place a system to track the progress of pre-proceedings work under the Public Law Outline. This will enable them to monitor the length of time this work is taking so they can be confident that children do not wait too long to have their welfare and safeguarding secured.

83. Effective work by Stronger Families with some older children who are at risk of becoming looked after has enabled them to stay with their family. However, although improving, edge-of-care services are not sufficiently coordinated to ensure that they are targeting all children and families who need this help. When a child needs to be looked after, clear family finding processes identify suitable short term placements without delay. Children are supported to live with siblings where this is in their best interests. Many children and young people speak positively about their placement and the relationships they have formed with their carers. Although many children looked after get their needs met, not all children benefit from stable placements. There has been an increase in the number of children who have experienced three or more placement moves in a year, and performance on long term stability has also declined in the past year and is poorer than comparators. The local authority is aware of this decline and is currently seeking to understand the reasons. Disruption meetings are not routinely held for individual placement breakdown, so the opportunity to learn is missed. Foster carers report a lack of support services such as respite care at times of emergency.

84. Disabled children and young people benefit from specialist placements that are commissioned in response to robust assessment and planning of their complex needs. During the past year a new home has been specifically commissioned to

meet the complex needs of three young men who had previously been living away from the borough.

85. Children looked after in Knowsley benefit from regular health, dental and optical assessments and plans, including assessment of their emotional well-being. All have a strengths and difficulties questionnaire (SDQ) completed which is used to identify potential issues for them in relation to their emotional health. Assessments result in appropriate referrals to specialist health provision including mental health services. In a small number of cases social work records did not contain enough information about the potential impact of health conditions for the children and their carers.

86. The educational attainment and progress of children looked after varies between year groups. Children in the early years make good progress but by the end of Key Stage 1 children looked after perform below the level of their peers. Progress is good for the very large majority of children across Key Stage 2 and exceeds that of their peers, particularly in reading. In secondary school the level of progress falls significantly and the gap between children looked after and all children in Knowsley is too wide. Educational outcomes for looked after children at Key Stage 4 are not good enough. A very small minority of children achieved five or more good GCSEs (A*to C including English and mathematics) in 2013, comparing poorly with the proportion for looked after children nationally and for others in their age group in Knowsley.

87. The quality of personal educational plans is variable. Some good examples were seen. Others did not contain a complete attainment history or targets that were specific or sufficiently challenging. In these the voice of the child is not always apparent.

88. The large majority of looked after children attend schools judged to be good or better, both in and outside Knowsley. The virtual school monitors the progress of Knowsley schools which fall below good in their inspection. Children who are looked after are not moved unnecessarily and careful consideration is given to each child's individual needs. Good joint working by the virtual school, inclusion officer and education support team has improved school attendance and reduced fixed term exclusions. No looked after children are permanently excluded. The pupil premium is used well to support children looked after and a sensitive approach is taken to address individual needs. Good transition arrangements are in place for looked after children leaving school. Visits to colleges are undertaken by education staff alongside looked after children as part of the on-going support. There is a strong partnership between the virtual school and the learning and skills and employability team.

89. For looked after children who are placed outside the borough, the virtual school is now improving systems to collect information from providers on the quality of education. Lack of information has previously made it difficult for the virtual head teacher to challenge external providers on progress made and the impact of any additional funding. Education and health colleagues are not routinely

involved in pre-placement planning and for children who are to be placed out of the borough. For some children this results in delay in securing appropriate local educational provision and health services to meet their needs in their new community.

90. An effective system of return home interviews ensures that, if young people go missing from care, they are seen by their social worker upon return, their voice is heard and coordinated services are arranged to reduce risk where needed. There are good working relationships between residential staff and staff in the youth offending service and a range of commissioned services are available to meet the needs of children looked after who are misusing drugs or alcohol.

91. Children and young people in care are represented by the children in care council and the 'making a difference everywhere' (MADE) groups. MADE groups, involve a good cross section of children looked after in Knowsley. Supported by a participation officer, they perform a very valuable role in collecting and representing the views of children and young people to inform service delivery. MADE groups also act directly to deliver improvements to services and have, for example, delivered training on equality and diversity to staff and foster carers. They review and comment on policies, and their work helps to ensure that social work for children looked after is focused on children's needs.

92. Most children and young people surveyed by MADE groups were confident that bullying and other forms of discrimination are taken seriously and tackled by staff. However, some felt that bullying directed specifically at children looked after is not always addressed effectively within schools; the MADE groups are developing training to deliver to secondary schools to tackle bullying.

93. Feedback collected by the MADE groups indicates that children who are looked after do not all receive the relevant leaflets explaining how to make a complaint, so the local authority cannot be confident all children understand the process. Knowsley does take robust action to investigate and learn from complaints, and commissions an advocacy and independent visitor service which is valued by children looked after.

94. Knowsley uses a range of externally commissioned and internally provided services to secure placements for all children looked after. Currently the internal recruitment of foster carers and the number of in-house residential placements is not informed by suitable sufficiency and recruitment strategies that are based on a robust needs assessment. The authority cannot assure itself that it is targeting recruitment or securing provision appropriately to meet the needs of its current and projected looked after population. During the past year the proportion of children looked after living more than 20 miles from home has increased.

95. Most children and young people who are looked after report good relationships with their social workers, with one saying 'she always checks up on me and that

I'm happy where I'm living, and if there are any issues she sorts them quickly'. Social workers consistently visit children, including those living outside the borough, at least within statutory timescales and more often in most cases; and they know the children well. Children speak positively about the relationships they have with foster carers, children's home staff and their reviewing officers. Some older young people and care leavers report they had previously experienced frequent changes of social worker and poor communication. The more recent feedback is demonstrating that this is improving.

96. Two young people living away from the borough who were tracked for the inspection were both visited regularly by their social workers despite the long distances involved. Their care plans reflected their current needs, including health and education, and the choice of home had been carefully considered in each case. Both were positive about the home where they were living. Neither had formed a working relationship with their IRO. In one case the contact arrangements were not satisfactory, with the mother unable to visit regulary due to the distance from Knowsley.

97. There are some examples of thoughtful life story work, with social workers and others engaging with children to help them understand the reasons they are in care. However not all children looked after benefit from this, particularly where a child's plan has changed from adoption. Tools and materials to support direct work are infrequently used by social workers.

98. The local authority seeks to engage children and young people more meaningfully in their reviews and is achieving some success in this area: for example, 10 children were supported to chair their own review during the last year. Additionally a care leaver is currently employed to consult with children and young people on their views about how reviews can be improved.

99. Knowsley is improving processes to secure permanence for children, for example through inviting adoption workers to the first review for the youngest children and by changing their previously over-optimistic strategy of seeking adoption for all children under 10 years. The local authority acknowledges that improvements are still required to ensure that permanence is considered by the second review for all children looked after. It is also encouraging IROs to offer more challenge to social workers' care plans to tackle drift and reduce delay. Although witnessed by inspectors, it is too early to evidence the impact of this new approach by IROs.

100. Most care plans require improvement to ensure that they establish actions that meet the child's assessed needs, including their need for permanency. Social workers know their children well and clear consideration of changes to the child's experiences and circumstances is evident in care planning meetings. However, tracking of progress against the written care plans is less robust, with evidence of drift continuing between meetings. There is also some confusion amongst workers about Knowsley's standards for the frequency of care planning meetings.

101. Good arrangements are made to support reunification and reduce risk where the plan is for a child to return to the care of parents. In these cases risk is thoroughly considered, and ongoing sensitive supportive work is provided to children and their families. However, in a small number of cases, when staff have to react to older young people moving out without a plan, the Placement with Parent Regulations are not consistently applied in a timely way.

102. The majority of looked after children and young people benefit from carefully considered and supported contact with their families. However there are issues about contact for a small number of children. This is the case where the plan for the child has significantly changed and the local authority has been slow to address this. The quality of recording is variable. For some children who have been looked after for a long time, the records will not help people to understand their history and experience in care.

103. Children and young people benefit from a range of leisure activities. This includes use of the central youth provision 'Our Space', which is open to specialist groups such as disabled children and children looked after while also being a facility for all young people in Knowsley during the evening.

The graded judgment for adoption performance is inadequate

104. It takes too long for children in Knowsley who become looked after to be placed for adoption when this is in their best interest. This is reflected in the most recent published adoption scorecard figures. The scorecard shows that over the last three years to 2013 children in Knowsley took on average 277 days longer to be adopted from first entering care than the average in other local authorities.

105. Senior managers recognise this is poor practice and are working to improve performance. In a small number of the most recent cases seen, there has been a significant reduction in the time taken between obtaining a placement order and matching the child with an adoptive family. However, managers are not yet confident that by their second review all looked after children have a plan for adoption when appropriate. As a result children may have already waited too long to be adopted by the time a placement order is granted.

106. Historically there has been a delay in finding a family for a child once a placement order had been granted. Knowsley now has a high number of children potentially awaiting adoption, with some 40 children currently subject to placement orders. Of these, 32 have been looked after for over 20 months, some since 2008, and they are still not placed for adoption. For many children, adoption may no longer be in their best interest. At the time of the inspection, work had commenced to review these cases and alternative plans had been identified for some of these children. Others were still waiting to have their plan re-assessed. For these children there has been significant drift in their permanency planning and the outcome of this is likely to be poor. For example, some children have had contact with brothers and sisters and parents stopped

in preparation for adoption, yet have no permanent alternative plan ensuring their stability.

107. New processes are being introduced to address the delays and improve timeliness. These include: alerts to the adoption team manager as children enter care; legal planning meeting minutes shared with the adoption team; and an adoption worker attending the first child looked after review; but these have only been in place since January 2014 and the impact is yet to be seen. Performance management information is not sufficiently robust to track children effectively once they enter care and the system designed to achieve this this has not been implemented as yet.

108. In order to improve adoption performance Knowsley has changed its policy of automatically considering all children under ten years old for adoption. Now only children under the age of five are considered. Robust action is therefore not being taken for some children who are over the age of five years who may benefit from adoption. There is no consistent approach to assessing sibling groups.

109. Currently children in Knowsley do not benefit from robust concurrent and parallel planning. For some children there is the potential for delay with the care planning processes divided across teams. Fostering for adoption is not implemented in practice. There is as yet no policy underpinning the use of fostering for adoption as part of the concurrent and parallel planning process. For some children whose plan has changed from adoption, life story work has not been completed. For these, further support will be needed to help them to understand the changes to their plans.

110. Knowsley is active in recruiting adopters and overall numbers are increasing, with more adopters being assessed in the current year than in recent years. With a rolling programme of training planned throughout the year to support the adoption recruitment process, no prospective adopters are waiting to access the training. It is too early to measure the impact that the new two-stage adoption assessment process is having in terms of increasing numbers of adopters available.

111. The assessments seen of prospective adopters were overall timely, but late medical responses from Health impact on stage 1 of the assessment and this has resulted in some delays in assessments being completed and social workers having less time to complete the stage 2 process.

112. All reports seen by inspectors about prospective adopters explored issues from their backgrounds, their experience and values and the reason they felt adoption was right for them. Reports were of good quality and appropriately scrutinised by the adoption panel.

113. The panel and agency decision maker ensure that children are suitably matched with prospective adopters through appropriate challenge. The low number of

disruptions indicates that this process is robust, with only one adoption disruption reported in 2013 to 2014.

114. The adoption panel has a diverse membership from differing professional backgrounds. Regular training is offered to panel members. Regular meetings are held between the agency decision maker and the fostering and adoption panel chairs to consider trends and patterns of activity at the panel.

115. There have been no complaints from adopters in the past year, and the feedback from adopters about the service they have received is positive.

116. Once a child is matched with a prospective adopter there is a thorough process of preparation and introduction. Appropriate support is provided to the adoption placement, including work with the birth children of the adoptive family to aid a smooth transition for the adoption to take place.

117. Children who are adopted and their adoptive families and birth relatives are informed of their entitlements to receive an assessment of their adoption support needs. A variety of support services is available to support adoptive children and families, with a service level agreement with 'After Adoption Yorkshire' to support birth families.

118. There are no ongoing adoption support packages in place, but the post-adoption support service is in the process of assessing two adoptive families to look at the package of adoption support services required to meet the needs of these families.

The graded judgment for the experiences and progress of care leavers is requires improvement

119. Young people leaving care and preparing to leave care receive support from the committed young people's team with a strong child-centred ethos that delivers many good outcomes. The service is not yet good because the quality of assessments and pathway plans is too variable, with some needing more depth and analysis to ensure that all care leavers' needs and risks are fully assessed as part of their plan. The electronic information system does not facilitate team workers in devising good quality assessments and pathway plans. Chronologies do not provide a clear history of significant events in the young person's life to support assessments and planning.

120. Health needs are clearly assessed and recorded and young people are satisfied with the help they receive. CAMHs is available to those who need this support. Young people do not receive written information on their health history in preparation for leaving care. Young people's records do not demonstrate whether they have been provided with information about their entitlements, how to complain or how to access advocacy services. This does not ensure that all care leavers have been provided with the appropriate information, advice and support.

121. The local authority has introduced a Staying Put policy but this is not yet fully understood by carers or young people. Both groups expressed concerns about these arrangements as a basis for enabling care leavers to remain in a stable supportive environment. Knowsley has a Pledge for looked after children and care leavers but not all care leavers are aware of it. The local authority plans to re-launch a new, more user-friendly Pledge developed with the children in care council.

122. The current wide span of control limits the ability of the young people's team manager to comply fully with the supervision policy and to quality assure and audit casework. There are plans for a deputy post but this was not in place at the time of inspection. The electronic information system does not provide timely or good quality management information. The young people's team has recently introduced reflective practice sessions into monthly team meetings and this learning is having a positive impact on work with young people. An example was the prompt recognition of the risks from child sexual exploitation and an appropriate plan to safeguard the young person.

123. All young people who spoke to inspectors confirmed that they feel safe and are safe where they live and in their home area. The local authority reports that all young people are in suitable accommodation and this was confirmed in talking to young people and in records seen. Applications for tenancies are prioritised in line with the protocol with the housing provider. Where young people are in secure accommodation there is good multi-agency planning involving the probation service and housing provider.

124. Young people can access their personal adviser by phone or call in and see a member of the team when they are in crisis or need to talk to someone. Manageable caseloads mean staff can provide a prompt response. Care leavers are well prepared for the transfer from a social worker to a personal adviser in the same team at 18 years of age. Vulnerable young people are helped to access adult services where needed and the team has the capacity and commitment to support those over 21 years who come back to ask for help. A high proportion of young people leaving care after age 16 remain in care until their 18th birthday.

125. Care leavers in Knowsley are well supported to access education, training and employment. The proportion of those engaged is improving and is above that of comparators and the national average. Effective links are in place between the learning and skills manager, the local college, training providers and voluntary organisations. Inspectors met with five care leavers who are very positive about the support they receive, including opportunities for volunteering as a pathway to work.

126. Care leavers are encouraged to be ambitious and show aspiration. Eleven young people are currently supported on degree courses at university. Care leavers enjoy the annual event to celebrate their achievements with senior officers and the Lead Member. 'Our Place' young people's centre is a valuable

resource providing opportunities to meet, engage and develop social skills. In 2013 Knowsley received the 'Catch22 From Care2Work Quality Mark' in recognition of its commitment to support care leavers in their journey to employment.

Leadership, management and governance are inadequate

127. The legacy of turnover and short-term appointments in the senior management group over the past two years has led to a loss of focus on the maintenance and development of services in response to need. The recent permanent appointments to the Director of People post and to other key senior management positions brings stability and permanency in the most senior positions. However the secure systems needed to ensure that leaders have a comprehensive knowledge of how well children and young people are helped, cared for and protected are not yet in place.

128. A test of assurance in relation to the dual nature of the responsibilities of the Director of People's post has not yet been undertaken. Given the volume of improvement work that will be required to ensure that services are safe and effective, the local authority should satisfy itself formally that there is sufficient senior management capacity to lead and manage Children's Services effectively.

129. The new senior management team is driving the recent positive developments, including identifying some of the key changes necessary to ensure that there is an improvement pathway for children's services. The authority has begun to implement an improvement plan which targets significant areas of weakness in front line services and support to staff. However, the plan is not comprehensive as it does not yet include the review and development of services for looked after children.

130. Strategies for commissioning services are insufficiently developed and lack clearly defined targets and timescales for achievement. In particular, the local authority does not collect and analyse information on the needs of children and young people in Knowsley. It does not have a comprehensive sufficiency strategy allowing it to link identified need to plans for provision. Fostering provision is not planned to match the complex needs of children coming into care. Current fostering resources are not well understood and managed.

131. The joint strategic needs assessment (JSNA) does not reflect current pressures on services and service response as most information and data is derived from 2010 and its 2013–16 joint strategy is mostly informed by the outdated JSNA. On that basis and despite the presence of the DCS on the board, children's social care issues are not prioritised as they should be.

132. Senior officers and lead members of Knowsley Council are aware of a number of significant deficits in the provision of services to children and families. There is full support from the Lead Member for the proposed re-structure of children's services to be better able to meet needs. This includes more effective access to early help and a re-design of fieldwork services to address too many children experiencing poor outcomes as a result of ineffective intervention by social care. This re-structure is currently underway, but initiatives already taken are too recent to demonstrate significant impact.

133. Recent developments include the implementation of a MASH to enable closer partnership working and information sharing between agencies. This development is very new, not yet embedded and requires the implementation of a new approach to early intervention and the common assessment framework to fully realise a better experience for children and families in need.

134. The understanding of inconsistent and often poor quality casework and management oversight is recent and is not informed by robust performance management. Currently there is no established quality assurance system. This has meant that concerns that senior management have about the quality of services are not systematically examined and results in the local authority not having a full understanding of the level of its effectiveness. For example, it has focused on safeguarding in recent months in attempts to identify issues in performance and has not had a similar focus on care planning and adoption.

135. There are examples of good individual services in early help and prevention, including a family support service offering intensive parenting advice and guidance and one to one work with parents on issues such as managing behaviour and emotional resilience. Other services include Encompass, freedom project and services for families and children with disabilities, including a range of parent support. These services are well used and valued by staff and families. However, these are not co-ordinated at a strategic level and not all families in need of a service are effectively identified at an early enough point to prevent further referral to social care.

136. Both the DCS and the chief executive recognise that the LSCB is not a fully effective working board and that it continues to be at a formative stage in fostering an understanding by all Board members of their role and the function of the board. Robust oversight is required to ensure that the Board continues to develop and embodies core processes to ensure that it has an understanding of each agency's contribution to safeguarding and offers effective challenge.

137. Frontline management oversight of practice is not embedded. There is a legacy of poor and irregular supervision of staff, particularly in the safeguarding and assessment teams, with some better practice seen in the children looked after team and the young people's team. While there has been very recent improvement over the last four months in ensuring that staff have regular supervision, the quality of supervision remains poor with little or no reflection or analysis offered. This has meant that decision making on cases is often not evidenced and supervision is not a learning experience for staff, and does not lead to improvements in services to children and young people.

138. A comprehensive training offer to staff includes detailed policies and processes for the support of newly qualified social work staff. Despite the training available, staff do not demonstrate the ability to use tools and research knowledge to enable them to work effectively with children and families. Many staff are positive about working in Knowsley and some have been in post for many years, especially in the children looked after and leaving care teams.

However, the experience of a significant number of newly qualified social workers has not been positive with a few having left or leaving because of poor levels of support and late senior management intervention, particularly in safeguarding and assessment teams.

139. The experience of many families, children and young people, particularly in safeguarding teams, has been of too many changes in social worker making communication difficult, with one parent saying that he had to tell his (painful) story too many times. Changes in social worker have in some cases resulted in delayed intervention and outcomes for children.

140. Senior managers are now more visible to, and more supportive of, frontline social workers. Staff are positive about these recent changes.

141. There have been sustained improvements in progressing care proceedings through the courts, with timescales reducing and now at 25 weeks. The local authority has a good working relationship with Cafcass, for example Cafcass cites Knowsley as an exemplar for responding to safeguarding requests, assisting Cafcass to report to court effectively in private law cases.

142. Knowsley has an active children in care council and effective MADE groups which are well supported by the participation officer. Knowsley has recently set up a corporate parenting board separate from the previous combined meetings with the children in care council to provide a greater focus on the strategic development of the corporate approach to children in care and care leavers. The board has been too slow in setting up and monitoring a work plan and current planned meetings are not frequent enough to ensure that clear direction and a significant work rate are established; on this basis the current board arrangements are not effective in ensuring good outcomes for children looked after.

143. While there is some improvement in permanence planning for looked after children and young people, permanent arrangements have not been secured for large number of children. Although an adoption diagnostic was undertaken in September 2013 the actions arising have not been tackled quickly enough to ensure that the right plans are being made and drift does not continue. The pace of change and management urgency to tackle these issues has not been quick enough.

144. Care leavers are appropriately supported in Knowsley and NEET performance is better than neighbour and national averages, reflecting the investment made by the local authority in employing two 'employability' officers in leaving care services.

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.

Section 2: The effectiveness of the Local Safeguarding Children Board

The effectiveness of the LSCB is inadequate

Priority and immediate action

145. The LSCB should review its business unit to ensure that sufficient capacity is available to conduct all the LSCB's business.

146. The LSCB should establish a multi-agency audit framework and obtain a commitment from all Board members and the managing bodies of each individual member agency to resource a programme of audits of practice across the partnership.

147. The LSCB should arrange to assess whether LSCB partners are fulfilling their statutory obligations under section 11 of the Children Act 2004.

148. The LSCB should review the policies and training provided to ensure that professionals in all partner agencies understand and apply the thresholds for access to services.

Areas for improvement

149. The LSCB should seek from the managing bodies of each individual member agency a renewal of commitment to the role and responsibilities of the Board and Board members.

150. The LSCB should ensure that focused training and briefing events take place on a regular basis on local and national lessons from serious case reviews and management reviews.

151. The LSCB should increase partners' understanding of and engagement in delivering services through the CAF model.

152. The LSCB should evaluate the effectiveness of early help services, and in particular check that help is delivered to those who most need it.

Key strengths and weaknesses of the LSCB

153. The Knowsley Safeguarding Children Board is not fully compliant with the requirements of Working Together 2013. In particular the Board does not have in place a robust means of monitoring and evaluating the effectiveness of what is done by the local authority and its partners individually and collectively to safeguard and promote the welfare of children. A very small number of cases have been audited which are insufficient to identify effectively lessons to be learnt. The Board has not established an ability to assess whether LSCB partners are fulfilling their statutory obligations.

154. The annual report does not provide a rigorous and transparent assessment of the performance and effectiveness of local services. For example, the report does not contain the results of Section 11 audits as none have been completed in either 2012–13 or 2013–14. The report also lacks contributions from member agencies on developments in their services and the effectiveness of their safeguarding services.

155. The Board is duly constituted in terms of membership, including two lay members, although there has been a significant turnover of the major agency representatives including health and the local authority throughout 2012 and 2013. This has affected the ability of the Board to establish itself and fully exercise its responsibilities.

156. Board functioning continues to be challenged by a lack of common understanding of members' responsibilities. Although the Board has had two successful development days for members, it is still regarded by some partners as being in its formative stage. The Chair of the Board continues to seek members' understanding and agreement to Board responsibilities and agreement on priorities for the Board.

157. The Board has not been able to publish its 2012–13 annual report on the effectiveness of child safeguarding and promoting the welfare of children in Knowsley in line with local agencies' planning and commissioning cycles. The 2012–13 annual report was published in May 2014. This means that the Board has not been able to publish in time to influence planning and decision making in other significant forums.

158. The LSCB has not implemented a regular program of multi-agency case and thematic audits, with only one audit (involving eight cases) being undertaken in 2013, no further audits currently planned and no other multi-agency audits completed since 2008–9. This is a significant omission in the Board's ability to assess the effectiveness of its constituent members and whether agencies are keeping children safe in Knowsley.

159. In December 2013, the Board established a learning and improvement framework which clearly outlines the processes by which the Board and its members review cases of concern, including decision making in serious case reviews and management reviews on cases which do not meet the requirements of serious case reviews. The dissemination of lessons learnt from serious case reviews and management reviews both locally and nationally are integrated into the body of training made available to multi-agency staff. The Board does not have a robust way of monitoring the impact of this learning on practice. Not all staff seen during the inspection where able to describe lessons learnt from these reviews. Integration of this information into the main body of training has not allowed for specific consideration of this learning in an effective manner for staff, and means that some staff are not sufficiently aware of steps they can take to minimise risk.

160. The Board has no current serious case reviews and one notification to Ofsted of a serious incident in December 2013 has resulted in no further action'

161. The LSCB has an appropriate range of sub-groups including a child death overview panel (C-DOP), a child sexual exploitation sub-group and a monitoring and evaluation sub-group. The CDOP has a clear overview of child deaths in Knowsley and understands its functions including the identification of trends and lessons to be learnt.

162. The child sexual exploitation (CSE) sub-group was established in July 2013 and the Board has been active in highlighting issues in relation to CSE and, for example, in promoting the creation of the multi-agency CSE (MACSE) group. The impact of this work is evident in how partners have benefited from the training. The sub-group, while identifying a requirement for a risk assessment in 2013–14, has not yet been able to complete this work.

163. The monitoring and evaluation sub-group identified in its 2013–14 work plan the need for work on Section 11 and Section 175 audits. These audits, the first for several years, have been initiated but are yet to be completed. The work plan does not currently include a programme of multi-agency case file audits.

164. The Board has been active in overseeing processes for children who go missing and children being bullied, and has supported the creation of 'Operation Encompass' to provide support to children and young people in schools who have had involvement in domestic violence. This has been a positive piece of work, with the schools now able to monitor more effectively those children who live in households with domestic violence.

165. The LSCB commissions an appropriate range of multi-agency training. A safeguarding training strategy details the range and level of training to be provided. Attendance at multi-agency training has increased annually. Evaluations of training take place and are mostly positive, but evaluation does not clearly establish its contribution to improvements in practice or the experiences of children and families.

166. The Board has recently put in place partnership protocols, including with the Children and Families Board, defining roles and responsibilities of both boards in relation to safeguarding. This helps to ensure that partners are clearly aware of what is expected of them and what they can expect of the Board.

    The Board's business plan for 2013–14 set out a number of appropriate priorities many of which have been achieved (these included the learning and improvement framework and a new performance framework). This reflected a greater focus on a number of key areas for development. Not all priorities were achieved in a timely manner, including publishing the annual report and an audit programme, which indicates that the Board, while making some progress, was still not able to achieve all it set out to do or ensure that core processes are put in place as quickly as they are required.

What the inspection judgements mean: 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.

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