

Calderdale Metropolitan 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 board¹

Inspection date: 13 January 2015 – 4 February 2015

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The overall judgement is that children’s services require improvement

The authority is not yet delivering good help and protection 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	Inadequate
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.

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The local authority

Summary of findings

Children's services in Calderdale require improvement because:

Senior managers and elected members, supported by partners, have shown clear leadership and worked hard to address areas of the service that were judged to be inadequate in previous Ofsted inspections and improvements have been made in a number of services.

Risk is now better managed and many children and families are receiving the services they need to help them and keep them safe. No children were identified as being left at immediate risk during this inspection and early help services are an area of strength.

Child Sexual Exploitation (CSE) is given a high priority in Calderdale and effective information sharing including the use of a central register, means that agencies have comprehensive and timely information about those most at risk and can coordinate services and plan interventions to reduce risk.

Looked after children have improving outcomes, but practice is not yet consistently good and progress in improving outcomes for children in some areas has been too slow. Children wait too long to be adopted and there are delays in the recruitment of adopters.

Concerted and focused performance monitoring has driven progress but is not yet effective in ensuring consistency in all areas of the service.

The quality of assessments is not yet consistently good and whilst good examples were seen, too many lack robust analysis of information to inform decisions.

Permanency planning meetings do not consistently consider all permanency options at an early enough stage. This means that in some cases there is delay in making the decision about the right permanency placement for children.

Child protection and child in need plans do not always include clear outcomes or timescales. Care plans are not always sufficiently clear about children's needs, how these will be met, and when this will be done by. Contingency plans do not always make clear what will happen if plans do not progress and when parents and carers fail to engage with plans, there is not always timely challenge.

Arrangements in relation to private fostering are not robust.

Some care leavers do not understand the purpose of pathway plans and not enough care leavers have access to apprenticeships.

Management oversight, including by Independent Reviewing Officers, does not consistently ensure a clear focus on children and young people's progress against plans.

The local authority senior leaders are aware of the improvements still required and have a clear plan to deliver these. There is still much to do to ensure practice is good in all service areas but good progress has been made to date.

What does the local authority need to improve?

Priority and immediate action

1. Ensure that there is focused work and robust management oversight to reduce the timescales that children wait to be matched and placed with adopters.
2. Improve the timeliness of adopter recruitment to reduce the time that children have to wait to be adopted.
3. Ensure that there is a robust analysis of the reasons for young people not taking up the offer of a return interview and that findings inform planning and commissioning to increase the uptake of return interviews when children are missing from home and care. Areas for improvement

Areas for improvement

Leadership, management and governance

4. Ensure that effective performance management and quality assurance further drive improvement and consistency in the quality of practice, and that assessments, planning and the use of chronologies are given priority.
5. Ensure that there is robust management oversight of plans, and appropriate challenge to reduce drift and delay, and that all managers including Independent Reviewing Officers are clearly focused on securing timely, permanent placements for children and young people.

Help and protection

6. Improve the quality of assessments including those for children at risk of CSE by ensuring that effective and robust analysis of all the information informs decisions.
7. Ensure that all children have plans which clearly record intended outcomes and identify timescales for actions, so that parents, carers and children know what needs to change to improve children's wellbeing and safety.
8. Ensure that there is appropriate challenge when parents and carers do not engage with plans, and that contingency planning clearly outlines the consequences of the plan not progressing.

9. Improve the quality and consistency of work that is undertaken with children who are privately fostered to ensure that statutory requirements are met. Ensure that there is senior management oversight of private fostering, to support improvement of recognition and response to this group of young people.
10. Ensure that the assessments undertaken of all young people who present as homeless consider the benefits of them becoming children looked after and, where assessments identify them as children in need, that this results in the provision of services through a robust child in need plan.

Looked after children

11. Improve the quality of permanence planning meetings so that all possible options for children are considered at the outset of their time in care.
12. Improve Independent Reviewing Officers' consideration and testing of the suitability of permanence plans for children, and ensure that this is clearly recorded in the record of looked after review meetings.
13. Improve the quality of care plans so that these are clearer about what needs to happen, how and when this will be achieved, and who is responsible, and include consideration of the purpose and intended outcome of contact.
14. Ensure that children's needs arising from diversity are consistently recognised and plans put in place to meet these.

Adoption

15. The Adoption Panel Chair to report annually to the local authority on the performance of the local authority at the panel.

Care Leavers

16. Ensure that pathway plans are useful and relevant to all care leavers, and that they understand the purpose of their plans. Make sure that the plans have clear objectives and timescales and detail clearly all actions required to meet the young person's key needs.
17. Improve opportunities for care leavers to have access to apprenticeships.

The local authority's strengths

18. Senior managers have taken concerted action to drive improvements in many services from a low starting point. This action, underpinned by good knowledge of local communities and effective joint commissioning arrangements, means that many children and their families have good access to a wide range of services to meet need, with support for early help being a particular strength. These services were seen during this inspection to be making a positive difference for many children and their families.

19. The local authority is a learning organisation. Independent audits and reviews have provided opportunities for external challenge and scrutiny. Many of the findings from these have been used well to focus on priorities that have improved services for children. These priorities fit well with the Calderdale Safeguarding Children Single Integrated Improvement Plan.
20. Partnership working is strong and this is evidenced in many areas. For example, the Early Intervention Panels which ensure effective information sharing and timely access to services, so that children and families are offered help when needs are first identified. This is reducing the need for formal social work intervention.
21. The Multi Agency Screening Team (MAST), co-located with the Child Sexual Exploitation (CSE) team, is resulting in timely decision making to ensure effective responses to referrals to reduce risks to children, including those at risk of CSE.
22. The use of the 'Central Register', together with a range of multi-agency forums, is resulting in effective and timely information sharing for those missing from home, care and education and those at risk of CSE. This means that agencies have comprehensive and timely information about those most at risk and can coordinate services and plan interventions to reduce risk.
23. The Women's Centre provides a wide range of services to meet differing levels of need for those at risk of domestic abuse and CSE. This means that many children and young people of different ages are receiving help to address risk and minimise harm.
24. The electronic recording system for children's services is regularly updated and enables social workers to record effectively, including clear recording of children's wishes and feelings, and supports performance management and monitoring.
25. The voice of the child is represented well across a range of areas; for example, young people are involved in developing the new children looked after strategy.
26. Most children looked after live in stable placements with families which are near to the communities they come from.
27. The Virtual School provides effective support to children looked after, including those who live out of borough. All children are involved in developing their Personal Education Plans (PEPs), including those in nursery and reception.
28. Social workers have manageable caseloads, which mean that they can spend time working directly with children and getting to know them well.
29. Workforce development within Calderdale is strong and consequently has had significant impact in ensuring stable, permanent social work teams and a reduction in the use of agency staff.

Progress since the last inspection

30. Ofsted's inspection of services for looked after children in February 2010 found services to be adequate, with safeguarding arrangements for children judged to be inadequate. Subsequent inspections of children in need of help and protection in 2012 and 2013 continued to judge services for the protection of children to be inadequate. The Secretary of State issued Improvement Notices in April 2012, January 2013 and January 2014.
31. Recommendations from the last Ofsted inspection in June 2013 included the need for improved management oversight of thresholds for access to services, improved practice in the management of strategy discussions and Section 47 enquiries and the need to improve assessment of risk when children are first referred to ensure that risk is appropriately addressed. Further recommendations included the need to use chronologies to ensure that historical information is considered in assessments and is informing decisions and for children's views to be sought and considered in assessments and planning. Transfer of cases between teams needed to take place without delays and performance management and audit embedded with themes reported to senior managers. Finally the need for sufficient social work and management capacity in the contact referral and assessment service was identified, and for staff to be suitably qualified and experienced.
32. This inspection found progress in many of the areas identified as needing improvement, for example management oversight of the application of thresholds for access to children's services is now consistent and robust. Response to referrals is appropriate and there is timely intervention and assessment for children who may be at risk. The management of strategy meetings has significantly improved and is now effective, and no children were identified during this inspection as being left at risk of significant harm. Transfer of cases between teams is timely and chronologies are now used in most cases to inform decision making about next steps.
33. The new electronic recording system is very effective in supporting social work practice, including the recording of chronologies and the recording of children's wishes and feelings in one dedicated site. Many social workers undertake direct work with children and this is helping them to understand children wishes and feelings.
34. Determined recruitment campaigns mean that there are now sufficient social workers and management capacity across the service to enable social workers to have manageable caseloads. There is commitment from the local authority that case loads will be monitored and additional funding for more staff provided if they increase.

35. The councils leadership team, with the support of an effective Improvement Board, and a comprehensive programme of audit and performance management has ensured that significant progress has been made in many, although not all, aspects of the service. However, practice is not yet consistently good across the whole service. Assessments do not always include a robust analysis of all information and plans do not always include clear outcomes and timescales. Contingency planning is not yet sufficiently robust. Further work and more focus on robust permanency planning at an early stage are needed to improve outcomes for children. The pace of change for children waiting to be adopted has been too slow and the recruitment of adopters takes too long in too many cases.
36. The local authority and its partners have the capacity and determination to improve performance with significant improvements in the workforce in place, strong partnership working in many areas of practice including CSE, an improving Local Safeguarding Children's Board and effective use of audit to drive improvement in some areas of the service. However performance management and audit need to clearly focus on the areas identified during this inspection as needing improvement and the level of challenge and management oversight of practice needs to be consistently robust across all areas of the service.

Summary for children and young people

- Services to help and protect children and young people in Calderdale have been poor for a long time, and in the past not enough children and young people received a good service. The senior managers know this and have been working hard over the last two years to make improvements, but they know there is more to do to make sure that all services are good.
- Partners and services work extremely well together when children and young people first need help. This means that problems can be sorted out quickly and very early on, before they become too difficult to cope with. We found that children and families who have suffered domestic abuse have very good support.
- Not enough children have good assessments and plans. Too many of these do not explain what children need, or how things at home affect them. They do not always explain what will happen and when, nor how the professionals responsible will know if the support is helping children and their families. We have asked the local authority to make sure that they use and learn from the good examples seen in some assessments and personal education plans to make sure that all plans for children are good.
- Children and young people who have plans in place receive support from a wide range of services and these services work well together to help different family members. Social workers work hard to get to know children and families well, and to make sure they have the help they need. For many children and young people, this is making a positive difference.
- The new systems to record, monitor and think about the risks to children missing from education, home or care are working to make sure that children and young people get the help they need. By working together, the police and local authority and others share the information they have to make children and young people safer. This means that these children get help from services more quickly, which helps to reduce risk.
- When children and young people cared for by Calderdale Council have brothers and sisters, social workers try to keep them together if that is what they want and it is best for them. However, some children need to be given more help so that they can understand what has happened to them in their lives and why decisions have been made.
- Social workers try hard to find adoptive families for those children who need it, but too many children in Calderdale have to wait too long, and much longer than children in some other parts of England, before they are adopted.
- Children and young people in care do well in Calderdale, especially as they move into Year 3 and above. Young people do particularly well in their GCSEs, and much better than children in care across the country. They are increasingly doing almost as well as the rest of the young people in Calderdale. More of you leaving care are going to university, but only a few of you are going into an apprenticeship.

Information about this local authority area³

Children living in the area

- Approximately 45,771 children and young people under the age of 18 years live in Calderdale. This is 22% of the total population in the area.
- Approximately 21% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
 - in primary schools is 17% (the national average is 17%)
 - in secondary schools is 13% (the national average is 15%).
- Children and young people from minority ethnic groups account for 17% of all children living in the area, compared with 22% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Asian or Asian British and mixed.
- The proportion of children and young people with English as an additional language:
 - in primary schools is 17% (the national average is 19%)
 - in secondary schools is 13% (the national average is 14%).
- Calderdale's minority ethnic population is mainly Pakistani, Indian and Bangladeshi. Other communities include those of Chinese, Black British and Eastern European ethnic origin, with the last of these growing as a population in the borough.

Child protection in this area

- At 31 January 2015, 1,278 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 1,252 at 31 March 2014.
- At 31 January 2015, 204 children and young people were the subject of a child protection plan. This is a reduction from 249 at 31 March 2014.
- At 31 January 2015, two children lived in a privately arranged fostering placement.

Children looked after in this area

- At 31 January 2015, 322 children were being looked after by the local authority (a rate of 70 per 10,000 children). This is a slight increase from 320 (70 per 10,000 children) at 31 March 2014. Of this number:

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.

- 109 (or 34%) live outside the local authority area
 - 16 live in residential children’s homes, of whom 31% live out of the authority area
 - 0 live in residential special schools⁴
 - 259 live with foster families, of whom 7% live out of the authority area
 - 27 live with parents, of whom 7% live out of the authority area
 - one child is an unaccompanied asylum-seeking child.
- In the last 12 months:
- there have been 21 adoptions
 - 19 children became subjects of special guardianship orders
 - 103 children ceased to be looked after, of whom 7% subsequently returned to be looked after
 - 12 children and young people ceased to be looked after and moved on to independent living
 - one young person ceased to be looked after and is now living in a house of multiple occupation.

Other Ofsted inspections

- The local authority operates three children’s homes. Two 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 April 2012.
- The chair of the LSCB has been in post since January 2014.

⁴ These are residential special schools that look after children for 295 days or less per year.

Inspection judgements about the local authority

Key judgement	Judgement grade
The experiences and progress of children who need help and protection	Requires improvement
<p>Summary</p> <p>Significant improvements have been made in services for children in need of help and protection but the quality of children’s experience is not yet consistently good.</p> <p>Early help services are well developed and coordinated in Calderdale. The Early Intervention Panels have promoted multi-agency engagement in early help, and this means that there is a wide range of support services to help improve the lives of children and families when needs are first identified.</p> <p>The number of referrals to children’s social care has reduced as a result of early help arrangements, including improved screening of domestic abuse notifications. Thresholds are understood with most children supported at the right level.</p> <p>The multi-agency safeguarding team (MAST) ensures effective information sharing in respect of children in need of help and protection, including those at risk of child sexual exploitation. Children and young people at risk of immediate harm are identified, and strategy meetings take place promptly to make decisions about investigations and actions required to protect children.</p> <p>The quality of social work assessments is not yet consistently good, and management oversight does not always provide appropriate challenge and ensure action when plans are not progressing. Child protection plans and child in need plans do not consistently prioritise actions, nor always have clear outcomes or timescales.</p> <p>Children who are subject to child protection plans have regular visits from their social worker and plans are regularly reviewed. Many children receive comprehensive support from a range of agencies to meet their needs and those of their families.</p> <p>An effective ‘Central Register’ of the children missing education, missing from home or care, and those at risk of CSE is supporting key agencies in working together, sharing information and ensuring timely and appropriate responses to those at risk.</p> <p>Arrangements in relation to private fostering are poor. There has not been enough work to identify children who are privately fostered, and current social work practice is not ensuring effective assessment and support for these children.</p> <p>The potential to accommodate vulnerable homeless 16- and 17-year-olds under section 20 (Children Act 1989), or to provide support through robust child in need plans, is not sufficiently considered at the point their needs are assessed.</p>	

37. Children, young people and families in Calderdale who encounter difficulties in their lives can access timely help and support through a wide range of early help services. There is an effective and comprehensive early help offer which is co-ordinated by locality Early Intervention Panels (EIP's), and this is having a significant and positive impact on outcomes for children. Through effective information sharing, the panels determine which agencies are best placed to provide help to children and families who need it. The wide range of agencies providing early help, including children's services staff, children's centres, schools and the voluntary sector, means that services can be provided to different family members according to age and need. For example, the Women's Centre, which has national recognition, offers early intervention work with 5-13 year-olds and there is good engagement with East European and Asian communities in children's centres. Parents and carers value these services and speak very positively about the difference they are making to their lives.
38. At the time of this inspection, there were 240 Early Intervention Single Assessments (EISA), which is slightly below the target set by the local authority and further work is needed to extend and increase the use of the EISA. Although the majority of EIA's are timely and clearly reflect the family history and reason for referral, too many do not reflect the experience of the child well enough. It is positive that cases that are subject to Early Intervention Plans cannot be closed without the explicit approval of the Early Intervention Panel, ensuring that children are only moved to universal services after multi-agency consideration of progress. In addition, robust step-down arrangements from Children's Social Care to EISA ensure that risks are effectively managed and children continue to receive support in line with their assessed needs.
39. Good support from the 'Troubled Families' programme is leading to improved outcomes for many children and young people. This service was reviewed in July 2014 by the Department for Communities and Local Government and the quality of family intervention and support work was judged to be 'outstanding'. This has resulted in Calderdale being able to deliver the expanded 'Troubled Families' programme early and reflects the range, effectiveness and positive impact of early help services.
40. The development of the Multi Agency Screening Team (MAST), with co-location of staff from health and education alongside social workers and police as well as access to electronic recording systems for adult services, is resulting in timely information sharing and decision making on contacts received by children's social care. A wide range of agency checks are undertaken, with parental consent where needed. The co-location of staff from the Child Sexual Exploitation (CSE) team at MAST is supporting the identification of young people who may be at risk of CSE, and ensuring that where the threshold may not be met for immediate social work intervention, information sharing and assessments of risk results in appropriate signposting of children and young people for further work.

41. The introduction of a new referral form since the last inspection has improved the quality of information provided by some agencies to the MAST, and many now include chronologies of agency involvement which supports timely decisions about next steps. Some referrals, however, do not contain all relevant information, and more work is needed to improve consistency in the quality of all referrals.
42. The rate of referrals to children's social care has reduced during 2014–15 due to improved understanding and application of thresholds and a new system for screening domestic abuse notifications. Domestic abuse incidents which do not meet the threshold for social work intervention are forwarded by the police directly to dedicated staff in the Early Intervention Team, who review them and refer those that require early help support to the Early Intervention Panel. Information is also provided to any professional working with the child, and schools report that this is enabling them to better support children in school. This approach ensures that children living in homes with domestic abuse can be provided with support at an earlier stage.
43. Previous inspections and audit work have identified low numbers of referrals from adult services to children's social care, and the local authority has undertaken a range of work to improve pathways from adult to children's services. This is beginning to have some impact, with contacts from adult services increasing from 83 during 2013–14 to 106 in the year to date and the local authority recognises that more needs to be done to further increase referrals rates.
44. Management oversight at MAST ensures that thresholds are appropriately applied in the majority of cases. Children in need of immediate assessment are allocated swiftly to the First Response Team (FRT); others are discussed at multi-agency referral meetings held at MAST to gather further information. This results in timely intervention and assessment for children who may be at risk. Strategy meetings are timely and are attended by a range of relevant agencies, and information is effectively shared. Minutes of meetings are well recorded and strategy meetings result in clear and appropriate decisions and timely child protection enquiries which consider risk and take appropriate action to protect children. In a small number of cases, single agency investigations were conducted which would have been more effective had joint investigations been initiated from the point of the strategy meeting.
45. The out of hour's social work service is effective in safeguarding children and young people. Arrangements for responses to concerns raised out of hours are appropriate and well-resourced. The quality of recording available to the daytime service is effective in ensuring safe follow up of activity.

46. The quality of assessments is not yet consistently good, with over half seen by inspectors requiring improvement. Better assessments seen included direct work with children to elicit their wishes and feelings, clear descriptions of the impact of parental behaviour on children, thorough consideration of family history and effective use of research to inform analysis of risk. However, too many assessments are too long and descriptive, and lack effective analysis to inform decision making. This means that in too many cases, not all areas of need are adequately addressed, and therefore children do not always receive all the services they need at the right time. The good examples of assessment work seen during this inspection need to be better promoted and shared across the workforce to drive further improvement and consistency in practice.
47. The timeliness of assessments reviewed within this inspection was appropriate in all cases, and children and families were receiving services in most cases before assessments were completed. All single assessments have a locally agreed timescale, and are reviewed by managers and only extended as requested by the social worker based on their early findings and the child's needs.
48. Chronologies are evident on electronic case files and this is an improvement since the last inspection. In some cases these are used well to consider historical information and key events, but some contain too much information, preventing them from being effective documents that really tell a child's story.
49. Systems and pathways for identification support and intervention regarding domestic abuse are well understood and used by partners. Multi-Agency Risk Assessment Conferences are well established and have a committed, consistent multi-agency membership which supports effective consideration and planning to reduce risk.
50. There is a wide range of services to meet differing levels of need in relation to domestic abuse provided by the Women's Centre. During 2013–14 the centre provided support to 596 women, 26 men and 145 children and young people. The extensive range of support means that children and parents can access services to meet differing levels of need ranging from early help and prevention through to support for children and young people subject to child protection plans. There is close multi-agency working and links with the 'Safe Hands' project in recognition of the links between domestic abuse and CSE, as well as established links with the Youth Offending Team (YOT) and Family Intervention Team workers who ensure that 'hard to reach' groups can access the Women's Centre. Effective multi-agency working is ensuring good access to an extensive range of services.

51. There has been significant improvement in services for children in need since the last inspection. Children in need are benefiting from co-ordinated multi-agency planning, which is regularly reviewed, and in many cases seen this was delivering effective support packages to children. Child in Need plans are of variable quality, with too many plans seen not having clear outcomes, or timescales. This does not support parents, children and professionals to understand how change will be measured and when it needs to happen.
52. The implementation of the Strengthening Families model is leading to improvements in the management of child protection conferences. The model is promoting a more focused approach to the identification and analysis of risk, and the needs of the child. This, together with the routine provision of advocates for children subject to child protection plans, has started to make some improvement in the participation of children and young people. Between October and December 2014, ten conferences had children present, and 39 children were represented by an advocate, resulting in children's views being independently represented at 43% of conferences. In one conference observed by inspectors, a young person was an active participant in the meeting. She was very well supported by an advocate, and this meant that her wishes and feelings were well considered in developing the plan. The vast majority (97.3%) of conferences are held on time, and in the majority of cases seen there was evidence of appropriate multi-agency attendance.
53. The rate of children (per 10,000) who are the subject of a child protection plan in Calderdale has decreased from 54.4 (2013–14) to 48.1 in quarter 3 of 2014–15, with 220 children on plans; this is now similar to statistical neighbours, and indicates that thresholds for children coming onto plans are now appropriately applied. However, in some cases there is evidence of a lack of robust challenge by conference chairs when plans are subject to drift and delay, and in some of these cases parents are not adequately challenged about their lack of engagement. Contingency plans are not always clear as to the long-term consequences of parents and carers not engaging with the plan.
54. In all cases seen, children had child protection plans in place and core groups were held regularly but the quality of planning is too variable. There were examples seen of good plans which were clear and focused on children's needs, and some examples of children's wishes and feelings, including those of very young children, influencing planning. However, in too many cases plans did not clearly identify the outcomes being sought and the actions and timescales required to achieve them. This means that for some children change may not happen quickly enough if families and professionals are not clear about what support will be offered by when, and how change will be measured.

55. As part of a multi-disciplinary team for children with complex needs, the children's disability team is well resourced in terms of skills and expertise to meet the diverse needs of children. Transition arrangements, whereby two transition workers spend one day a week within the disabled children's team, ensure that children's needs are identified at an early stage and appropriate resources commissioned.
56. There was evidence in most case records of effective consideration of children's needs in respect of their culture, religion and language, which results in a better understanding of children's needs. This included the use of interpreters, the translation of documents, and the allocation of support workers who were able to speak the same language as families. Effective direct work is undertaken by social workers in many cases, and this is helping them to develop meaningful relationships with children.
57. Clear procedures in respect of children missing from education ensure that all professionals understand their role. Education inclusion, education welfare and schools work closely together to take effective steps to locate and promote the welfare of children missing education. There were a total of 83 children missing education during the year, and at the time of the inspection nine children were missing from education, four of whom had been contacted and appropriate steps taken to establish their whereabouts of the other five. A strong and effective 'central record' of all the most vulnerable children and young people in Calderdale has been established that includes all those missing from education, those not receiving their full educational entitlement, all children missing from home or care and those at risk of CSE. The record incorporates information on other risk factors, such as Special Educational Needs and young people known to the Youth Offending Team. The record is updated on a daily basis by the Vulnerable Young People's Coordinator, and can be accessed by the police, children's social care and the Head of Learning. All children on the 'central record' have a key worker. This process supports key agencies in working together and sharing information to develop strategic and individual responses to protect children and young people. At the time of the inspection, there were four children missing from care, and none missing from home. 24 young people were identified as being at risk of CSE and all were receiving support from the specialist 'Safe Hands' project, and this was seen to be reducing risk to young people in cases seen during this inspection.

58. There are well established systems in place to support information sharing and the assessment and identification of young people at risk of CSE. CSE is managed through a dedicated team who meet daily to review and plan multi-agency responses to the young people who have come to the attention of any agency that day, and to review those known to be an ongoing concern. The weekly multi-agency meeting, which involves the CSE team, Police, Education, Safe Hands, and YOT, review all ongoing cases of CSE. Information from both meetings is added to the central record on a daily basis. Evidence has been seen on case files of these operational meetings providing clear analysis and assessments of the level of risk to young people and producing action plans to address needs and reduce risk. Children and young people who require social work intervention are allocated to a social worker from the CSE team and 11 young people were open to the social worker at the time of the inspection. In cases seen during this inspection, children and young people are receiving timely and effective intervention from a range of agencies to provide the support they need and reduce risks in relation to CSE. In some cases, young people would have benefited from a more holistic assessment and support plan, to ensure that other needs were also met. This has been brought to the attention of the local authority, who are taking immediate steps to address this.
59. In all cases seen, children who are missing from home or care are tracked and monitored and appropriate action taken to find children missing. Children who are missing are reported to the children's social care portfolio lead and tracked by the police and individual agencies as well as through the 'Central Record' and a monthly multi-agency 'missing children' operational meeting. This group is responsible for identifying patterns and trends involving CSE, missing children and trafficking. When serious concerns were identified through the analysis of return interviews, there was good evidence of appropriate action that resulted in reducing the risks to young people of CSE.
60. Attempts are made to contact all children who have been missing to see if they agree to a return interview and in the vast majority of cases (93%) contact is made, but only 40% of children agree to an interview. All children who have been missing will receive a visit from the police and from their social worker if they have one. The local authority recognises the need to increase the uptake of return interviews and is reviewing the order in which children receive visits from professionals and return interviews in an attempt to increase the uptake. Not all interviews are undertaken in the timescales required, and in recognition of this the local authority has recently secured funding for an additional member of staff to undertake return interviews. Return interviews are not always uploaded on to children's records, and are therefore not readily available to inform decision making.
61. Currently, 75 electively home-educated children are known, and their education and welfare is monitored effectively. Reasons for elective home education are carefully scrutinised and any patterns or trends are analysed and, if necessary, acted upon.

62. The virtual school has developed provision for the education of children who are on Child Protection Plans. The provision focuses on children, whose attendance is below 85%, providing six-week blocks of support to help the child to improve attendance and outcomes. Currently, progress of this work is being monitored and there is evidence that aspects such as behaviour and attendance improve, particularly whilst the support is in place. In one case seen, the virtual school had made a significant contribution in helping a young person to re-engage with school. It is as yet too early to analyse the longer-term impact of this work against outcomes at key stages.
63. The local authority is not fully discharging its duties in respect of children who are in private fostering arrangements. Despite some publicity during 2014, the number of private fostering notifications remains low, with only four received during the year, and only two children privately fostered at the point of inspection. Although children are identified as children in need, and are the subject of single assessments, work which specifically addresses private fostering requirements is not always carried out. Whilst this has not placed children at significant risk in cases seen during this inspection, it has affected the quality of their care planning.
64. The local authority designated officer (LADO) role is well established and effective. 149 referrals were received from a range of employers in 2013–14 and were responded to and investigated in a timely way. In 2013–2014, 91% of LADO cases were concluded within a month, and 99% within three months. The LADO also offers advice and training to agencies, and evaluation of work is incorporated into the annual report to the LSCB.
65. There are arrangements in place to provide vulnerable 16- and 17-year-olds who are homeless with emergency accommodation and assessments of their need. Assessments result in support being provided, but do not evidence consideration of the benefits of them becoming looked after, nor do they always result in robust children in need plans. In cases seen, all young people were provided with support, but some would have benefited from closer multi-agency working via a child in need plan.

Key judgement	Judgement grade
The experiences and progress of children looked after and achieving permanence	Requires improvement
<p>Summary</p> <p>Most looked after children in Calderdale are supported well by the local authority and live in stable placements but planning for their future is not always timely and this means that some children wait too long for a permanent placement.</p> <p>The children in care council is well developed and is well supported by the local authority.</p> <p>There is a good range of placement choice, meaning that most children are placed close to home and that brothers and sisters are able to live together when appropriate.</p> <p>However, care plans are not always sufficiently clear about children’s needs, how these will be met, and when this will be done by.</p> <p>Children missing from care are tracked and monitored effectively and offered return interviews by an independent person. Those identified as at risk of CSE are offered appropriate support to reduce risk.</p> <p>Most children looked after do well in school, and their progress is effectively tracked by the virtual school; specialist support is available when needed. Personal education plans are generally well written, and the views of children are used to set targets for the following year.</p> <p>Permanency planning meetings do not always consider all permanency options early enough, and in some cases this causes delay in securing permanency for children. Independent Reviewing Officers’ critique and oversight of plans, including permanence plans, is not sufficiently robust in all cases.</p> <p>Cases in the pre-proceedings phase of the Public Law Outline (PLO) do not always progress quickly enough, though more recent work is better in this regard. Letters before proceedings, which set out the changes the local authority expects parents to make, do not always do so with sufficient clarity.</p> <p>Children in Calderdale wait too long to be adopted and there are delays in processes to recruit adopters. A range of measures have been put in place to address shortfalls in practice, but have not yet had time to affect performance sufficiently and more needs to be done to improve practice.</p> <p>There is a range of adoption support services in place and these are valued highly by adopters. There has been only one adoption breakdown in the last three years.</p>	

Almost all care leavers live in safe, suitable accommodation that meets their needs. Robust challenge and support, and effective collaborative working are ensuring that increasing numbers of care leavers are in education, employment or training. Not all pathway plans have clear objectives and timescales, or enough details of the needs of young people.

66. The number of children looked after has fallen from a peak of 355 at 31 March 2012, to 326 at the time of the inspection. At around 70 per 10,000, the proportion of children looked after in Calderdale remains higher than the national average of 60 per 10,000. This is partly as a result of appropriate action being taken on a number of cases which had drifted due to previous poor practice, and where children have now become looked after or been made subject to proceedings. While appropriate action has now been taken, in some cases children should have become looked after sooner.
67. Thresholds for becoming looked after are now understood and appropriately applied through the Gateway Panel. Inspectors saw no cases where children had entered care inappropriately.
68. For cases currently in the pre-proceedings phase of the Public Law Outline (PLO) process, progress is not always timely, but more recent work shows improvement. Letters before proceedings are clear about the local authority's concerns, but some contain lengthy lists of actions for parents which are not sufficiently focused on outcomes for children and which do not have clear timescales. This makes it difficult for parents to know what is expected of them and by when. Parents have legal representation at meetings to discuss the concerns. Family group conferences are offered to support families to identify ways forward, but the impact of family group conferences in reducing the need to enter proceedings is not fully understood by the local authority.
69. The average duration of care proceedings has fallen from 36 weeks in 2013–14 to just under 32 weeks for completed cases and the figure for cases currently in proceedings has improved further and is now better than the national average at just under 27 weeks. Partners feel that there have been improvements in the local authority's court work and that relationships between social workers and children's guardians are improving. Guardians are included in key meetings when appropriate, and regular liaison between IROs and guardians was seen on some cases.
70. The multi-agency Vulnerable Young People's Panel is effective in identifying support for children on the edge of care who experience problems of drug and alcohol use, offending, adverse peer relationships or CSE, to prevent them having to become looked after. In cases seen, Vulnerable Young People's workers, together with a range of agencies, were engaging well with young people aged 13 to 17 and providing appropriate levels of support to prevent admission to care.

71. Almost one in ten (9%) of the local authority's children looked after are placed with parents on care orders. The 'placement with parents' reports completed by social workers and signed off by senior managers are of variable quality, though do identify risks adequately. Managers monitor these cases on a quarterly basis, but there remain some cases where long-standing plans to discharge care orders have drifted and only recently been put into action. This means that some children have remained in care for longer than necessary.
72. In recent planning for children to return home from care, risks were considered and are monitored closely and appropriate support provided. Overall, a low proportion (7%) of children currently looked after have previously been looked after within the last 12 months, indicating that children and their families are well supported to prevent the need to return to care.
73. Following the adoption diagnostic in early 2014, the local authority implemented an action plan which included the establishment of a specialist family finding team and allocation of family finders at the point of a child going into proceedings, to prioritise the identification of permanent placements. There has been a rise in the use of Special Guardianship Orders (SGOs) from 10 in 2013–14 to 17 in the first three quarters of 2014–15. SGO assessments are thorough and detailed, and social workers provide good support and transition planning to children moving to relatives under SGO arrangements.
74. Permanency planning meetings are held on most cases from an early stage. In most, consideration is given to the assessment of family members as potential carers, and for younger children the possibility of adoption is often considered. However, discussions do not always adequately address important issues early enough, such as whether brothers and sisters should remain together or be placed apart, or the wider range of permanence options, such as Special Guardianship. This means that comprehensive plans to secure permanence are not always in place as quickly as they should be.
75. Social workers see children regularly, see them alone and know them well. The views of children and young people are regularly sought by social workers, are presented in recording and can directly influence changes. However, where children are not in support of the care plan, and will need help to understand why the plan is not the one they want, it is not always clear that this been discussed in detail with them.

76. There is an active advocacy service, which attended 33 reviews in quarter three of 2014–15. The opportunity for children to have an advocate is routinely discussed at looked after reviews. An independent visitor service is available for those children who have little or no contact with anyone independent of children's services, and is currently working with 21 children. Young people spoken to were aware of how to make a complaint. When children make complaints, these are listened to and resolved, with children being offered apologies and explanations for the reasoning behind the local authority's response. Learning from complaints has been incorporated into training for social workers; for example, the importance of ensuring timely, clear information for children about planned changes in their placements.
77. There are clear anti-bullying policies in the local authority's children's homes and, when incidents occur, staff work with young people to promote understanding and help to prevent recurrence.
78. A low proportion of children looked after were involved with the criminal justice system between April and December 2014. There is regular monitoring of and reporting on offending by children looked after by the Youth Offending Team (YOT) to ensure that patterns and trends are understood and young people can be provided with the support they need. The YOT is represented at key decision making forums such as the Vulnerable Young People's Panel, where plans to support young people are discussed and agreed, and this ensures effective support to those young people who are looked after. There is a range of services available to young people who misuse substances, both through schools and through a specialist drugs service, 'Branching Out'.
79. Children looked after at risk of child sexual exploitation are allocated to the social worker in the CSE team, and so receive a specialist service. In cases seen, the work undertaken had helped to reduce the risk to children over time. Children going missing from care are considered as part of the same system that responds to children who go missing from home. Children placed within the borough and those placed within 20 miles of the authority have return interviews conducted by the 'Safe Hands' project. For those children living more than 20 miles from the authority 'Safe Hands' contact a local Children's Society project or identify another agency to conduct a return interview.
80. The proportion of children looked after having medical and dental assessments on time is high, and 10% above the national average. Health assessments are robust. This means that children and young people's health needs are addressed in a timely way, and where concerns are identified referral to the relevant agency is prompt. A dedicated tier-three mental health service provides children looked after with timely support, and is currently working with around 100 children and young people.

81. Children and young people are supported and encouraged to make good progress. Almost all (97%) attend good or better schools. The few children who are in a school requiring improvement are there because the school has only recently been judged to require improvement. The local authority considered the implications of this for individual children and made decisions based on their needs; their attendance, behaviour and progress are closely monitored. There are no significant differences in educational outcomes between children looked after placed within or outside the authority.
82. There is still more work for the local authority to do in relation to school readiness. Children do not make good progress in their early years or at Key Stage 1, and their attainment is not as good as national performance for children looked after. However, by the time they complete Key Stage 2 their attainment exceeds that of their peers nationally: in 2013/2014 attainment at Key Stage 2 in mathematics was 20% higher, in reading 14% higher, and in writing 9% higher than nationally. This represents a significant improvement on the previous year, and reflects the impact of the collaborative monitoring and challenging of pupils by their own school and the virtual school.
83. The attainment and progress of children looked after in secondary schools are similarly good. The proportion of pupils attaining five good GCSEs including English and maths was 42.1% in 2013-14 significantly above that of similar pupils nationally at 14%. The gap with other young people in the local authority is narrowing as the figure for Calderdale is 59%. In this same year the percentage of children looked after making the expected level of progress increased by 36% in English, and 10% in mathematics.
84. Personal education plans (PEPs) are detailed and clearly written. They capture the voice of the child well, and use this creatively to set targets for the following year. In early years and reception, an excellent range of methods, from observations to play and drawing, are used to capture the views of younger children. Reviews of progress are thorough and articulate clearly the progress children and young people are making. Robust and challenging audits of the PEPs completed each week monitor their rigour and usefulness.
85. Tracking of pupils by the virtual school is scrupulous, and is used to identify trends and issues. PEP targets align closely to the allocation of Pupil Premium Funding, and the virtual school monitors the use of this well. Where there is insufficient evidence of the appropriate use of this funding, it is withheld until further evidence is obtained.
86. No children looked after have been permanently excluded since 2007. The virtual school works in close partnership with schools, alternative providers and providers of individual tuition to ensure that all children looked after receive their full educational entitlement. Currently, only two young people are not accessing their full entitlement, and they are closely monitored and receiving a good range of support.

87. The local authority keeps an appropriate record of children and young people they are directly responsible for who are accessing alternative provision, and monitors the quality of this provision. However, until very recently, the number of children and young people accessing alternative provision through schools has not been recorded by the authority. As a result, the authority does not yet have a full understanding of the extent and quality of this provision.
88. Children's leisure interests are considered as part of their looked after reviews, and support for these is provided well, for example through the fostering allowance. Foster carers are clear about their responsibilities in respect of delegated authority, and welcome the freedom this gives them to make day-to-day decisions for children.
89. All children have care plans, but some plans contain a lot of detail without sufficient focus on the specific needs of children, the intended outcomes and timescales for actions to be completed. Children's views are represented in most, though not all, plans and consideration of permanency is not always sufficiently robust.
90. Independent Reviewing Officers (IROs) are aware of the importance of their role, however their oversight and critique of care plans and permanence plans for children is not always sufficiently robust. The dispute resolution process has been recently revised, and this is beginning to show signs of impact, with an increased number of issues being raised by IROs and monthly reporting to the Senior Management Meeting of all issues identified in cases. Looked after reviews are held regularly and within timescales, and consider the day-to-day arrangements for children well. IROs are beginning to monitor progress between looked after reviews, and notes of this monitoring were seen on some cases. Children attended their reviews in 60% of cases between April and October 2014, though their views were represented at 87% of meetings.
91. Children have contact with those who are important to them. Contact arrangements are set out in care plans and scrutinised in reviews. However, the purpose of contact and its intended outcomes should be more carefully considered to show how it is meeting children's needs. Contact arrangements and their purpose should be more clearly recorded in children's plans.
92. The needs of children placed outside the local authority, including their educational and health needs, are addressed well. It is notable that workers from the advocacy service will travel to see children placed out of authority, even when these placements are at some considerable distance. This provides additional assurance that the voices of these children will be heard effectively.
93. Placement stability in this authority is good; in the past 12 months, 8.6% of the children currently looked after have had two or more placement moves, below the most recent national figure of 11%.

94. Very few children (3%) are in placements with external providers which are not good or better, and where a placement falls below standard there is a clear protocol in place to respond to this and make decisions in children's best interests about whether it is safe for them to remain in placement.
95. There is a good range of placement choice. Children live in placements which meet their needs. This is well managed by the central placement finding service, which is able to consider all options available to identify that which will best meet these needs. Few children (4%) are placed more than 20 miles outside the local authority, and this number has reduced. Overall, 62% of children looked after are placed within the local authority's borders compared with 60% for England as a whole, and 65% of children are in placements provided directly by the local authority. Placements with external providers are monitored effectively through the Resources for Children Panel to ensure that they continue to meet children's needs. The local authority's work on placement choice includes membership of the regional commissioning consortium, which provides it with a good range of choice in fostering, residential, and post-16 placements.
96. Assessment, scrutiny at fostering panel, supervision and training of foster carers is done well. Foster carers receive regular support and supervision; the majority say they feel support is available when they need it, and are enthusiastic about the training on offer to them. The local authority has targeted its foster carer recruitment at carers who will be best placed to meet the particular needs of the children who are becoming looked after. Twelve fostering households were approved in 2013–14, while nine households ceased to foster. Reports to the fostering panel are detailed, comprehensive and thorough in evaluating risk factors, and receive appropriate scrutiny and challenge from the panel.
97. When children are placed with carers, there is careful consideration of the individual child's needs and the capacity of the adult to meet them. Children are well prepared for making transitions to permanent carers, and social workers provide transition plans and some direct work to help the child make the adjustment and understand what is happening.
98. A review of life story work has been undertaken in recognition that this work was not carried out to a consistent standard and not all children with a plan for permanence had life story books. This has resulted in all children who have been identified as needing this work receiving it, or work is ongoing. This means that some children have had to wait too long for work to help them to gain an understanding of their identity and family history, but that plans are now in place to meet this need. Recording on children's case files is regular and comprehensive, though it is sometimes not sufficiently focused on progressing the care plan.

99. The children in care council, Right 2 Voice, has been well supported with its development. The group is clear and confident in its purpose, and engages positively with corporate parents, helped by a 'getting to know you' exercise undertaken by young people, elected members and officers at a meeting of the corporate parenting panel. It can point to areas in which it has had an impact on local authority policy and practice, such as the development of an internet safety policy for children looked after and the inclusion of young people in interviews for social workers. It is acknowledged that there is more work to be done to further engage the wider children looked after population; the group has plans in place to address this, and is being solidly supported to do so.
100. Cases were seen where there had been good responses to children's needs arising from diversity. However, this was not always the case, with some examples where needs arising from identity had not been addressed as carefully and thoroughly as they should have been.

The graded judgment for adoption performance is that it is inadequate

101. Children in Calderdale wait too long to be adopted. The adoption scorecard reports that between 2011-2014 children in Calderdale waited on average 742 days from coming into care to being placed for adoption. This is 195 days above the national target and 114 days longer than the national average. Quarter 3 data this year shared by the local authority indicates that there has been a further slight deterioration in current performance, with Calderdale children now waiting on average 746 days; 199 days over the government target and 118 days longer than children in other parts of England.
102. Data for 2011-2014 shows that children with a Placement Order in Calderdale waited 358 days, to be matched, 141 days longer than children nationally, and 206 days longer than the government target. Performance in 2014 was worse than in 2013, increasing from 337 to 358 days as a three year average. Quarter 3 data for 2014/15 supplied by the local authority indicate that performance has deteriorated further at 458 days, and now children in Calderdale wait 335 days over the government target and 268 days longer than children wait on average nationally.
103. In the three year period up to March 2014 only 33% of children adopted in Calderdale waited less than 18 months between entering care and being placed with adoptive families, compared with 51% in England, using a three year average. On this measure Quarter 3 data supplied by the local authority shows that the three-year average has now improved to 36%, and that performance counted during the year has now reached 44.7%. This is an improvement but is still well behind the England average and there is more to do to close the gap.

104. A range of measures have been put in place since the adoption diagnostic in March 2014 to address shortfalls in practice and these have begun to make a difference, but they have not yet had time to affect performance sufficiently.
105. A Permanency Policy and a range of new systems were implemented from April 2014 in Calderdale to ensure that children are now considered for adoption at the earliest stage. This includes the Gateway Panel at point of entry into care and the Permanency Panel, which meet six-weekly for all children where adoption is a possibility. Calderdale performed consistently well over the last three years in respect of the proportion of children leaving care for adoption, with 26% in year 2013–14 which is 4% higher than statistical neighbours.
106. The local authority also places more children from a Black Minority Ethnic (BME) backgrounds than other local authorities nationally. Seventeen per cent of children placed for adoption between 2011 and 2014 were of BME background compared with 8% nationally, which reflects the proportion of the child BME population locally.
107. There were insufficient adopters approved to provide a home for children needing adoption at 31 March 2014. At that time there were 45 adopters approved in Calderdale waiting for a match and 65 children who needed placements. Currently, Calderdale has 19 adopters who are waiting to be matched and 55 children with an adoption plan (Quarter 2 data). The discrepancy between adopters available and children waiting is currently 36, which is a now greater than 10 months ago. Some of the gap is mitigated by the fact that, due to its small size, Calderdale places up to half of its children outside its area and also uses a range of external adoption agencies and the Adoption Register to find adopters. Despite these efforts, this still leaves more children needing an adoptive placement than there are adopters available for them.
108. A small number of the children who waited the longest were disabled with complex health needs living in stable foster placements. Some of these children have been waiting in foster placements for as long as six years with their need for permanency only being recognised and addressed very recently. They have now been either placed for adoption or adopted by their foster carers. This means that whilst living in homes that met their needs well, historically these children did not have the security of an adoptive placement.
109. This cohort of children has had a disproportionate impact on the overall time that children wait in Calderdale, but delay is not limited to these children.
110. Analysis of child-level data provided by the local authority at the time of the inspection shows that out of the 44 children subject to a Placement Order, only 16 are currently in an adoptive placement and just four have been placed within the government target. Of the 28 children subject to Placement Orders without a match with an adoptive family, only one could potentially meet the government timescales for adoption at the time of inspection.

111. Delay in progressing adoptions has been due to a number of factors historically. These include insufficient focus on reducing delay in the planning for children in care, poor practice in family finding such as sequential planning, and practice of not placing children in Calderdale itself. In addition the local authority were not proactive in seeking to secure adoptive placements for some children who were seen as 'difficult to adopt' and who were living in stable foster care arrangements that were meeting their needs.
112. Following a diagnostic of the adoption performance last year, a number of recommendations have been implemented to improve performance. Managerial and social work capacity has been increased through use of the Adoption Reform grant, a dedicated family finding pod has been created, tighter permanency planning mechanisms have been implemented, and a tighter focus on timeliness has been achieved through the adoption tracker. A tighter grip has been evident in cases over the last three or four months.
113. There has been progress in changing practice: for example, recently half of Calderdale children have been placed inside the local authority following individual risk assessments. Family finding has started earlier in the adoption process, and family finders now start engaging with children coming through the Gateway Panel. Family finding is now more effective and comprehensive, making use of the Adoption Register, the regional consortium, Adoption Link, voluntary adoption agencies, monthly exchange days, and national events to find potential adopters. However, there is more work to do to build on these relatively recent improvements and reduce delay. For example, the matching of children to adopters is not yet done simultaneously at adoption panel when approving adopters.
114. Strategies such as Foster to Adopt and concurrent placements, which are designed to reduce the time children wait, are still at a very early stage. Just one Foster to Adopt placement has been recently approved and there are no concurrent placements currently available, although this is now being explored as part of a regional approach.
115. A successful adoption recruitment drive took place in 2013–14 which attracted 178 enquires and led to 25 adopters being recruited. This momentum of recruitment has been sustained and Calderdale is on target to exceed its recruitment from last year.
116. Calderdale's recruitment processes are in line with government requirements, and the checks and assessment of potential adopters are thorough. However, last year the timeliness of processing new adopters was poor in the majority of cases. Only six out of 19 adopters were recruited within six months, and analysis of current practice indicates that delay in processing approvals continues to be a feature. The adoption team has streamlined the application process to improve the consistency of response, but more needs to be done to reduce drift and delay in the recruitment and assessment of new adopters.

117. Calderdale has a range of support mechanisms and groups in place for adopters and children, and adopters know what support is available and value the service highly. This includes a newsletter, a parent and toddler group, single adopters group, and network events such as Picnic in the Park during the summer. Therapeutic support is provided by CAMHS or the Calderdale Therapeutic Service (CTS). A Young Advisors Group engages adopted young people in social events and uses their input to inform and improve service delivery from an adopted child's point of view. Disruptions in Calderdale are low, with just one in the last three years. A review of a recent disruption is currently underway to learn lessons.
118. The adoption service provides support services for all adopters living in its area. There have been 22 new requests for post-adoption support since April 2014 and 21 of these households are receiving a package of support. Where placing outside its area, the adoption service links adopters up to the multi-agency network and local resources available within those areas. Life story work for adopted children seen by inspectors was of a high standard and helped young people to understand their history well. Ninety-three per cent of children who have been adopted have received life story work.
119. Case work examined by inspectors indicated that the support to adopters and adopted children needs to be more child centred, to reflect the child's voice, be informed by more robust assessments, and have SMART plans. In one adoption case seen, the child's needs had not been thoroughly assessed, including the need to consider referral for a strategy meeting to decide if there was a safeguarding issue that required further investigation. The local authority took immediate and appropriate action to address these concerns when raised by an inspector. More needs to be done to raise the performance and quality of case work to support adopted children, and to ensure that safeguarding concerns are properly recognised and dealt with.
120. The adoption panel is properly constituted, and supported by high quality medical advice and an educational psychologist. It is now providing effective challenge and scrutiny of matches and adopter applications. Panel members receive training annually and performance is appraised annually by the Chair. Panel minutes provide a clear record of the issues discussed and the reasons for decisions taken. The Agency Advisor quality assures Prospective Adopter Reports (PARs) and the Child Permanency Reports (CPRs) before they are presented, and these are thorough and detailed. The Panel solicits feedback from adopters and this is used to reflect on the way that the Panel is managed. Agency Decision Maker decisions are taken within timescales.
121. The Corporate Parenting Panel receives an annual agency report and six monthly updates on the work of the adoption panel. They do not however receive a separate report from the Adoption Panel chair and the Adoption Annual Report for 2013–14 did not contain any feedback from the Adoption Panel Chair both of which would further enhance their ability to fully scrutinise the work of the Adoption Panel.

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

122. While there are strengths in some aspects of the care leavers service, not enough care leavers understand the reason for their pathway plans, risk assessments for temporary accommodation need to be more robust and the pledge has only recently been published and not all care leavers spoken to understand what this means for them.
123. Almost all care leavers spoken to report that they feel safe where they are living. They know where they can go to in an emergency and most are confident that, should they need it, help will be there. Effective partnership working between the pathways team and key partners such as Safe Hands ensures that care leavers receive appropriate information about all aspects of staying safe, including the risk of CSE.
124. Pathway planning is in place for all care leavers over the age of 16, and all have an up-to-date pathway plan. Plans scrutinised by inspectors contained an overview of the young person's history, and current factual medical information. Despite pathway advisers knowing their young people well, and understanding their vulnerabilities, recording of this in plans is weak. Targets do not clearly state what needs to happen and by when, or who will support progress towards agreed targets.
125. In most pathway plans the voice of the young person is clear, and increasingly there is evidence that the young person is completing the plan themselves. However, when talking to care leavers, not all of them could identify the usefulness of the plans. A few care leavers expressed concern that reviews took place in venues which they felt were not suitable, such as their foster home, making it more difficult to discuss sensitive issues.
126. All eligible care leavers are offered a health assessment and uptake is 100%. However, too many care leavers are not clear about their entitlement to receive their health history. This means that they may not know about important details when accessing or receiving medical treatment. This is currently a key focus for the designated nurse for children looked after and care leavers. To support this, a dedicated nurse is currently located within the leaving care team for two days a week, working with care leavers to develop a health information card that will enable them to access their health records.

127. Care leavers receive good support to develop their independence through programmes and activities such as the Goal Group, the Tenancy Programme and the Sunday lunch group. Care leavers spoken to report that they are confident to ask their adviser if they need specific help. Most spoken to say that the leaflets and other information they receive are helpful in supporting them to develop their independent living skills. Despite this, they identified that more specific help with managing money wisely would be useful.
128. Tenacious and persistent targeting, and programmes such as Project Challenge, are successfully engaging and re-engaging more young people in education, employment and training. The latest data held by the local authority demonstrate the positive impact of this rigorous approach, with 18.6% of care leavers currently not in education, employment or training, compared to the national figure of 38%.
129. Of the full cohort of young people leaving care over the last three years, 11 (10.2 %) are in years one to three of a university course. They receive good financial support during their time at university, and are particularly appreciative of the bursary they receive when graduating. Although numbers are increasing, and the figure is above the national figure for all care leavers (6%), it is considerably lower than the figure for all Calderdale school leavers.
130. Currently only three care leavers are on an apprenticeship programme. Although the authority guarantees all care leavers an interview for an apprenticeship, it does not have a ring-fenced apprenticeship programme to support care leavers. This therefore restricts the choice of options open to care leavers when they prepare to leave school.
131. At 95.2%, the proportion of care leavers living in suitable accommodation is high, and well above statistical neighbours and the national average. Bed and breakfast is rarely used for under 18-year-olds and no care leavers were in bed and breakfast accommodation at the time of the inspection. One care leaver was in a house of multiple occupancy. On the infrequent occasions when this is used, it is for very short periods. The local authority acknowledges that risk assessments of such temporary accommodation need to be more robust, in particular through working with the police and the local community to identify areas of risk and vulnerability prior to placing young people. Despite this lack of documented risk assessment, pathway advisers closely monitor all young persons placed in short-term accommodation through frequent visits and telephone calls. Strict boundaries for the young person around aspects such as overnight visitors further mitigate and manage risk. Long standing and effective partnership working with landlords and housing also ensure that young people accessing temporary accommodation are safe. A very new risk assessment process which is currently being implemented more appropriately addresses all key risks in a locality, and pays particular attention to CSE, drug misuse and crime.

132. Overall, young people have a good choice of accommodation and are given ongoing support throughout their transition to independence. Only a few care leavers are currently taking advantage of the 'staying put' policy, but those who are report that it is providing them with a helpful bridge towards independence. The local authority is extending the level of support to young people in residential care by establishing independent accommodation close to a residential unit. Young people will be able to live there independently, but receive support from the residential unit should they need it.
133. Transition planning for care leavers within the disabled children's team begins at the age of 16, providing an opportunity for trust and relationships to develop before the move onto adult services. This considered planning enables the complexities of young people's needs to be well understood before they move to adult services. For those young people with learning difficulties and/or disabilities who do not meet the thresholds for the disabled children's team, planning for transition takes place through annual reviews from Year 9 onwards. Independent travel training has a very high priority in Calderdale and is central to the aim of enabling all young people to live independently. For children with disabilities and special educational needs (DSEN), this training starts in Year 5.
134. A Care Leavers Pledge has recently been published, involving young people in the process, although many care leavers spoken to do not understand what the pledge meant for them and many were not aware that it existed. Although most are clear that they can make complaints, care leavers do not know the processes to follow should the need to complain arise.

Key judgement	Judgement grade
Leadership, management and governance	Requires improvement
<p>Summary</p> <p>The senior management team has worked determinedly, supported by partners and political leaders, to improve services for children in Calderdale. Significant progress has been achieved, but improvement in some key aspects of the quality of practice is yet to be embedded to ensure that children and young people receive a consistently good service.</p> <p>The Director of Children’s Services (DCS), the Chief Executive Officer (CEO) and elected members of the authority understand their roles well and have demonstrated a clear commitment to working with the Improvement Board to address the serious shortcomings previously identified through previous inspections of Calderdale’s children’s services.</p> <p>Partnership working, for example the multi-agency early intervention service and multi-agency screening team (MAST), provide a good base from which to develop and sustain improvement.</p> <p>The effectiveness of the local authority’s performance management and the quality assurance processes has been critical in driving improvement across a range of services. However, these arrangements are not yet having sufficient impact on the quality of assessment work or on care planning and performance in the adoption service.</p> <p>Management oversight and the quality of supervision are improving but are not consistently good in ensuring a clear focus on children and young people’s progress.</p> <p>The Independent Reviewing Officer (IRO) service does not provide sufficient challenge to ensure that children’s plans progress and timely action is taken to secure their long-term future and security.</p> <p>Commissioning is well developed and informed by strategic priorities, resulting in some effective multi-agency services to address child sexual exploitation, children missing from home and education, and domestic abuse.</p> <p>The workforce development strategy has had significant impact in securing the stability of social workers to support children and young people.</p> <p>An effective focus on the voice of the child is developing and is influencing planning.</p> <p>Education outcomes for children looked after in Calderdale are improving and the virtual school works well in partnership with the schools.</p>	

135. Child protection arrangements in Calderdale have been judged to be inadequate since 2010. The Secretary of State for Education has issued three improvement notices since then, in 2012, 2013 and 2014. The pace of change to drive improvements in practice has increased over the last year, since stability in the senior and middle management of the service has been secured. With the support of an effective Improvement Board, significant progress has been made in many, though not all, aspects of the service. The pace of change for children waiting to be adopted has been too slow. The local authority recognises that there is more work to be done to ensure consistency in the quality of practice across most services and to improve services for children for whom the decision is adoption.
136. There has been concerted and focused performance monitoring, with evidence in some cases of effective case work leading to good outcomes for children. Despite this, the quality of social work practice identified through case tracking and sampling in this inspection was too variable overall in respect of the quality of assessments, analysis of information, care planning and the use and quality of chronologies.
137. Management oversight of practice is a key area within the improvement plan. Whilst inspectors saw some evidence of consistent and effective management oversight, in some cases tracked, the rationale for decision making was not always clear, recorded or appropriate. In addition, when plans were not progressing and parents and carers were failing to engage, this was not always challenged by managers or practitioners.
138. The local authority self-evaluation in 2014 acknowledged that the IRO service needed to be more challenging of individual social workers' practice. This resulted in an overview of IRO work by managers, including a revision of the dispute resolution process, resulting in a quarterly report of challenge, which is beginning to have an impact in driving improvement. However, in some cases there remains insufficient focus on planning by IROs, contributing to delays for long-term planning for children and young people.
139. There has been a history of poor practice and performance in adoption in Calderdale for some years. Although a range of measures to address the issues identified have been put in place by senior managers following the adoption diagnostic in 2014, they have not yet had time to sufficiently improve performance. This, together with a lack of consistent and robust early permanency planning, means that too many children continue to wait too long to be adopted.
140. Governance arrangements in Calderdale ensure clear lines of accountability for senior managers, leaders and elected members to discharge their individual and collective statutory responsibilities.

141. The Chief Executive takes an active interest in the progress and outcomes for children and young people in Calderdale and meets regularly with the DCS, Lead Member for Children's Services and Chair of Calderdale Safeguarding Children Board (CSCB).
142. The Lead Member is proactive in pursuing the agenda for children in Calderdale. A weekly briefing on children's service performance, and attendance at the CSCB, complements governance arrangements, ensuring that he has good oversight of priorities and progress across the improvement agenda.
143. There is effective oversight by the scrutiny panel, with a focus on pertinent issues for the local authority, including the report of the CSCB, the ongoing CSE agenda and education achievements. Action planning and tracking of progress is evident, with a work plan that is reviewed and updated at each meeting.
144. The Children and Young People's Strategic Partnership Planning Framework links effectively with the JSNA, commissioning strategy and safeguarding plans to ensure multi-agency partnership commitment to the identification and prioritisation of local needs.
145. The Chief Executive, Chair of the Improvement Board and Lead Member have confidence in the positive trajectory of change within Calderdale's Children's Services, and acknowledge that this progress is due to the determination of the DCS and his senior management team working effectively together, developing a culture to drive improvement.
146. Progress in Calderdale is enhanced through feedback and external reviews. Areas of current focus for the improvement plan have been informed by the local authority's own self-analysis and a range of external challenge and review including: peer reviews of front door; children looked after and care leaver services; and adoption diagnostic.
147. The local authority works effectively with other strategic bodies. The Chair of the Improvement Board identifies strong and improving partnership working since March 2013 as being critical to progress in Calderdale. This, together with highly effective commitment from senior managers, politicians and partners, means that significant progress has been made in improving frontline services for children and young people in Calderdale. The Early Intervention Service is effective and well-established, and MAST and First Response Teams are ensuring timely and appropriate responses to referrals. This commitment is underpinned by some effective strategic planning to tackle the key priorities for the authority and its partners.

148. There has been good engagement from partners in the Improvement Board and suitable arrangements are in place for the transfer of responsibility for the delivery of the single integrated improvement plan to Scrutiny, the Health and Wellbeing Board and the Local Children's Safeguarding Board. The Chair of the Improvement Board is satisfied that the strengthened LSCB is now able to take responsibility for appropriate aspects of the plan and she has given a commitment to remain in her role to oversee any transfer of the plan.
149. A coordinated multi-agency approach to tackling CSE is resulting in increased identification of children and young people at risk, and targeted action to address and reduce risk. The number of recorded cases of CSE has increased from 27 cases in the year 2013–2014, to 27 cases in the first 2 months of year 2014–2015. The police are increasing the use of Child Abduction Notices as a result of increased intelligence, from 14 in 2012-13 to 27 in 2013–14.
150. The police have led on a range of initiatives with specific communities in Halifax to promote preventative work around CSE. A sensitive and considered approach led by the Neighbourhood Cohesion Manager has brought together members and key stakeholders within the community to develop a community-based approach to the prevention of CSE. Whilst some of this work is at an early stage, a good level of engagement across the community is evident and strong trusting relationships with the police have begun to develop, which provides a solid foundation for raising awareness and recognition of warning signs and the likelihood of increased reporting of CSE.
151. In recognition of the increasingly high level of domestic abuse in the authority, the associated costs to a range of agencies, and the lack of a strategic understanding of need in relation to domestic abuse, a JSNA for domestic abuse has been developed. This has enabled services to have a shared understanding of needs and gaps within services. The Health and Wellbeing Board has endorsed a strategic approach to domestic abuse, with input from key partners such as health, the police, children's social care and the voluntary sector. This has resulted in a common commissioning framework utilising pooled budgets, as well as funding from the Transformation Challenge Award, to ensure that services are targeted to meet need; for example, funding for a project to work with perpetrators.
152. The sufficiency plan is clearly aligned to the JSNA and strategic plans such as the CYPP framework to ensure that priorities are addressed and children and young people can benefit from a range of appropriate services. Effective regional networks such as the White Rose partnership ensure good quality and value for money in placement choice. External placements have reduced with the provision of more foster carers. However, recruitment campaigns for adopters have yet to ensure that the individual and complex needs of some children can be met in a timely and appropriate way.

153. Children and young people are supported through effective joint commissioning arrangements based on needs analyses which involve consultation and feedback from children, young people and families. Strong collaboration with commissioning partners in Calderdale, including the clinical commissioning groups (CCGs) and Public Health, has resulted in CCG funding for an additional CAMHS post to support vulnerable children with their emotional health and well-being.
154. Performance monitoring and quality assurance processes for commissioned services are robust, with effective arrangements for monitoring poor performance and inadequate providers to ensure that children and young people have good placements. All current registered placements for children and young people are judged good or adequate by Ofsted. One service recently judged as inadequate has been decommissioned.
155. Commissioning underpins the improvement and progress within Calderdale, supporting key strategies such as CSE, children missing and domestic abuse. 'Safe Hands', a commissioned service from the Children's Society, supports vulnerable children and young people, and includes those at risk of sexual exploitation. 'Safe Hands' also provides one-to-one support for children, training to Calderdale Safeguarding Children Board and return interviews for children who have been missing. Further achievements include the commissioning of two voluntary organisations to manage the 21 children's centres in Calderdale and the electronic health needs survey (eHNA) questionnaire, which has been rolled out successfully across schools and is being further developed for sixth-form pupils. The eHNA supports strategic priorities in identifying issues such as self-harm amongst children and young people, to inform effective commissioning and action plans.
156. The local authority has a clear commitment to corporate parenting and this is demonstrated through providing support such as a leisure card. The vast majority of councillors have undertaken training in corporate parenting. Young people have begun to attend the panel on a regular basis to present the views of the children in care council. As a result, the panel has had influence in developing local authority policy on children looked after, for example in respect of internet safety. The panel receives a range of performance information to enable it to hold officers to account. Some aspects of corporate parenting are less developed. For example, the panel does not yet have a method on place to review progress on publicising the 'pledges' to children looked after and care leavers.

157. Performance management and quality assurance processes have been integral to improving frontline social work practice. Progress is seen through the results against some key performance indicators and improving outcomes for children and young people. For example, re-referral rates are slowly reducing and referrals for domestic abuse are now appropriately signposted and appropriate action taken. Section 47 enquiries show a drop in volume from the very high level of 1,127 in 2013–2014 to a potential total of 615 (based upon six months' data) for 2014–2015 which is in line with statistical neighbours and national averages.
158. Auditing is used effectively to consider areas of performance and provide an analysis of issues. For example, a themed audit to consider children on child protection plans for more than two years was undertaken. This resulted in some improvements in identifying potential cases of drift. These cases are now 'flagged' in the electronic recording system at 15 months duration, to enable decisive action to be taken where needed. Consequently, performance figures for open child protection plans show a reduction in children on plans for two years or more. Of the 220 open cases in 2013–2014 the percentage of child protection plans open for two years or more was 9% (compared to 2% for statistical neighbours and 3% for England). This has now reduced to a current level of 6%, but this is still comparatively high.
159. The electronic recording system for children's services (CASS) supports social work practice and performance management and monitoring. CASS has been upgraded to reflect the need for improvement in practice and to support workers in effective recording. For example, chronologies can easily be edited by workers to ensure that only significant information is included and the recording of the voice of the child can be filtered to provide an overview of this aspect of work. A further positive feature has been a recent development whereby children and young people can electronically provide their views and opinions onto CASS.
160. The voice of the child was a key area of improvement for the local authority, and some excellent progress has been made in incorporating their views across a range of areas. Young people are involved in developing the new children looked after strategy, and have commented on and assisted with the development of the CSCB website and the content and design of the Yoyo (young people's) website. Importantly, young people commented on, and their voice was instrumental in changing, terminology from 'looked after children' to 'children looked after'. Further evidence of consultation with children is included in the commissioning of services, for example CAMHS, and more recently two young people have been co-opted to the local authority scrutiny panel.

161. Workforce development within Calderdale is strong and consequently has had a significant impact in ensuring stable permanent social work teams and a reduction in the use of agency staff. In 2014–2015 the vacancy rate was 8.7%, compared with the England rate for 2012–2013 of 14%. The use of agency workers in 2013–2014 was 7.4%, while the England rate for 2012–2013 was 12%. Further improvements have been made, and currently there is a very low vacancy rate of four posts in total. As a result of the commitment to workforce development and stability, data for December 2014 showed that social workers have manageable caseloads averaging around 17 children. Alongside the significant improvements in the stability of the workforce is the cross-party commitment to the 'caseload calculator', the system whereby increasing demand can be monitored and funding provided for additional workers to ensure that caseloads remain manageable.
162. Comprehensive training packages are available to staff at all levels. This includes career development training in leadership for managers and senior managers and a rolling programme of training to support frontline practice and development. All training is evaluated and feedback used to develop appropriate courses to support staff in their work. Current training on systemic practice is being rolled out across the local authority to support improved practice in how teams respond to and work with children and families.
163. The local authority recognises the critical importance of both good quality supervision and effective management oversight. Social workers and their managers are enthusiastic about the 4x4x4 model of supervision which the local authority has adopted, and about the training that is being delivered to support it.
164. Supervision practice is improving, is generally regular, and includes reflective consideration of work, personal impact and good practice issues. However, sometimes recording does not include evidence of reflection, and supervision of personal advisors within the care leaving service is not as consistent or rigorous. In addition to face-to-face supervision, managers undertake observations of practice, and undertake staff appraisals.
165. Learning from serious case reviews is taken forward and social workers reported having access to workshops. Senior managers use information from the evaluation of complaints and serious case reviews to prioritise and improve practice such as quality of assessments and management oversight.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement

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

Summary of findings

The LSCB requires improvement because:

Effectiveness of scrutiny and challenge

- The LSCB is meeting its statutory responsibilities, but there is more to do to secure the changes made and embed the progress of the last 12 months so that newly implemented systems, processes and frameworks are fully effective.
- The performance management framework and scorecard are still evolving. The multi-agency data set is incomplete and this limits the Board's ability to provide effective scrutiny in all areas.
- The reach of Section 11 audits needs to be extended, both in terms of the issues and areas covered by the self-assessment questionnaire and the number of organisations that complete it. More needs to be done to ensure that the results are subjected to rigorous challenge and are moderated effectively.
- Although comprehensive, the CSE action plan needs to be more outcome-focused and SMART. Targets need to be clearly identified against all actions in order to measure progress in all areas.

Private fostering

- More needs to be done to raise awareness amongst partners of private fostering arrangements and increase the number of notifications. The Board needs to ensure that the local authority's response to private fostering arrangements is meeting statutory requirements.

Multi-agency training

- The LSCB does not have a comprehensive multi-agency children's workforce strategy which sets out clear standards and expectations, and this means that the LSCB is not yet in a position to ensure that all those involved in working with children and families are suitably trained and competent or that training resources are being targeted effectively.
- The impact and effectiveness of multi-agency training is not evaluated to evidence impact.

What does the LSCB need to improve?

Areas for improvement

Managing the response to CSE

166. Revise and update the CSE action plan to ensure that it is outcome focused and measures impact in all areas of work.

Effectiveness of scrutiny and challenge

167. Ensure that the performance management framework for the LSCB includes a comprehensive multi-agency data set that will provide information about all aspects of service delivery and enhance the ability of the Board to routinely evaluate and monitor frontline practice across the agencies.
168. Ensure that Section 11 audits are completed annually by all agencies and organisations involved in safeguarding children and young people, that audits include questions about CSE and learning from serious case reviews, and that results from audit are subject to rigorous challenge.

Private fostering

169. Undertake further work to raise awareness amongst partners of private fostering and ensure that the local authority reviews and strengthens the response to private fostering arrangements to ensure that it is meeting its statutory responsibilities.

Multi-agency training

170. Develop a comprehensive multi-agency children's workforce strategy, and evaluate the impact and effectiveness of the multi-agency training that is being delivered to ensure that those working with children and families are suitably trained and that training resources are being targeted effectively.

Openness and transparency

171. Ensure that the minutes of Board, Business Group and sub-group meetings are more accessible and enable stakeholders, including children, young people, parents and carers, to monitor the LSCB's activities and hold it to account, and that they are easily accessible on the LSCB website.

Inspection judgement about the LSCB

172. The appointment 12 months ago of a new Independent Chair and Business Manager brought to an end a period of considerable turbulence, during which time the LSCB lacked focus and failed to provide robust scrutiny and critical challenge. Since then, considerable progress has been made in making sure that the LSCB is fit for purpose. While it now meets its statutory responsibilities, there is still further to go in ensuring that new systems, processes and frameworks are fully embedded and enable the Board to monitor and evaluate multi-agency frontline practice more effectivity.
173. Effective governance and clear reporting arrangements have now been established between the LSCB, the Children and Young People's Partnership Executive, the Health and Wellbeing Board and the Improvement Board. Partner agencies are well represented on the LCSB and membership is at an appropriately senior level to ensure that action agreed at the Board can be taken forward. This joined up approach means that the Board is starting to exercise greater influence; for example, partners are now giving the safeguarding agenda a higher profile within their own governance arrangements, priorities are suitably aligned to the improvement plans and the Board has begun to take responsibility for some aspects of the plan.
174. The LSCB has been restructured and its business processes extensively re-engineered in order to ensure that it can hold partner agencies to account, drive improvement in safeguarding practice and demonstrate impact and effectiveness. Priorities have been refined, are clear and explicit and are targeted appropriately. The work of the seven sub-groups is informed by a SMART business plan which is aligned to the Improvement Plan and the Children and Young People's Plan. The sub-groups' activities are well coordinated by an energetic and effective Business Group which reports directly to the Board.
175. A culture of openness and transparency, fostered by the Independent Chair, means that Board members, including lay members and representatives from the voluntary and community sector, feel confident and able to question and comment. There is increasing evidence of effective challenge. For example, the LSCB queried the level of data and analysis in the Independent Reviewing Officers' (IRO) annual report and has asked for more information about the role of the IROs in chairing child protection conferences. It has also asked the Local Authority Designated Officer (LADO) to provide a breakdown of allegations by sector and profession in order to be able to identify any trends or patterns.

176. There is, however, room for improvement in the way in which the minutes of Board, Business Group and sub-group meetings are recorded. They are not easily accessible to anyone who was not present at the meeting and does not have access to background papers. Similarly, while the LSCB website has been revamped, minutes of Board and sub-group meetings are not being routinely uploaded onto it. This lack of transparency means that the LSCB is not fully accountable, and limits the ability of stakeholders, including children, young people, parents and carers and to monitor its activities and hold it to account.
177. Strengthened performance management arrangements mean that the Board is better able to scrutinise frontline practice in order to safeguard and promote the welfare of children and young people. The new performance management framework provides data and detailed commentary on a number of key indicators around early help, child protection, looked after children and adoption, and leadership and governance. However, the data set is incomplete and this limits the Board's ability to provide scrutiny in all areas.
178. CSE is given a high priority in Calderdale. Well-developed structures, systems and procedures, underpinned by a clear strategy and coherent action plan, are evidence of a collective determination to tackle child sexual exploitation. Awareness has been raised; in the last academic year 2,340 secondary school pupils attended awareness raising sessions, and more recently training delivered to hoteliers has generated an increase in the volume of intelligence received and acted upon.
179. The Proactive and Responsive sub-group is responsible for driving partners' response to missing, CSE and trafficking, receives data on children missing from home care and education and is able to evidence both reach and impact leading to improved outcomes for children, young people and families. For example, a dedicated police officer linked to children's homes ensures that all children looked after, including those placed in Calderdale by other local authorities, have 'trigger plans'. This has led to the local authority identifying a reduction in the number of missing episodes.
180. However, there is more to do. Although reasonably comprehensive, the CSE action plan is neither outcome-focused nor sufficiently SMART; milestones are conflated with tasks which are not always specific, and lead to progress statements that are generally descriptive. This makes it difficult to measure progress.

181. Through the Early Help and Prevention sub-group, the Board has effective oversight of, and has made a significant contribution to, the introduction of the Early Intervention Single Assessment and the review and revision of the Continuum of Need document and the 'Signatures of Risk' guidance. Early help is an area of real strength in Calderdale. The fact that 70% of cases return to universal services following early intervention means that more families are having their needs met without the need for formal social work intervention. A judicious approach to the choice and timing of multi-agency audits around, for example, children looked after and care leavers, neglect, pre-birth assessments and the effectiveness of the joint adult/child protocol means that the Board's awareness and understanding of frontline practice is increasing, and contributes to the improvement in services to children and young people.
182. While Section 11 audits are being used to evaluate the strength of individual organisations' arrangements for safeguarding and protecting children and young people, the process is not yet sufficiently robust. The audits rely on self-assessment, and more needs to be done to ensure that the results are subjected to rigorous challenge and are moderated effectively. Their reach also needs to be extended, both in terms of the issues and areas covered and the number of organisations that complete it. Currently the Section 11 audit does not include questions about CSE or learning from Serious Case Reviews (SCRs), and in 2014–2015 only 60% of schools and some, but not all, commissioned services completed an audit. The Board's three-year strategy incorporates plans to address these issues and a compact with the voluntary and community sector is close to being finalised.
183. Lessons learnt from the 2014–2015 Section 11 audits are being acted on. Safeguarding procedures have been given greater prominence on the LSCB website and a poster distributed to all agencies. Where the audit identified a lack of knowledge or understanding of safe recruitment and/or the role of the Local Authority Designated Officer (LADO), specific training is being provided to address the shortfall. A task and finish group has also been charged with reviewing the multi-agency supervision framework.
184. The Child Death Overview Panel, shared with Kirklees, is efficient, effective and performs better than the national average in terms of data completion, the percentage of child deaths that are subject to a review and the throughput of cases within the year. 19 children who died in Calderdale between 1 April 2013 and 31 March 2014 were notified to the panel, 2 of whom were not immediately reviewed as the decision had been taken to commission a Serious Case Review.

185. Serious Case Reviews (SCRs) have been the focus of considerable time and attention over the last 12 months. Three separate SCRs are about to be published, one of which dates back to 2009 but which, for legal reasons, it has not been possible to publish before now. The Serious Case Review Framework has been comprehensively re-written and the Learning and Improvement Framework revised. There is evidence of increased rigour around the commissioning, scrutiny and publication of SCRs. Action plans for the three SCRs which are about to be published are SMART, and the agencies responsible for implementing them will be required to attend formal challenge events and provide evidence to demonstrate that lessons have been learnt and recommendations implemented.
186. The LSCB and its partners have not waited for the SCR reports to be published before taking action. One SCR led to the development of the neglect strategy and multi-agency toolkit, the replacement of the Common Assessment Framework (CAF) with the Early Intervention Single Assessment (EISA), the adoption of a joint adult and child protection protocol and the establishment of the Maze project for male victims of domestic violence. In response to another SCR, health are now routinely collecting and sharing information on young people who attend Accident and Emergency as a result of self-harm, and the dispute resolution process for children looked after and child protection has been revised. Learning from SCRs is disseminated in a number of different ways, including the use of multi-agency reflective practice sessions, learning lessons leaflets and the LSCB's website.
187. Lessons learnt from multi-agency audits have been, and are being, used to improve outcomes for children and young people by focusing on key aspects of the child's journey. For example, a multi-agency audit on referrals from primary schools to the MAST resulted in action to improve communication and the quality of information provided at the first point of contact. Partner agencies are now able to get professional advice from the MAST without needing to make a formal referral. A new schedule of multi-agency audits, commissioned in response to identified risks, has been developed to ensure that in future audit resources are targeted effectively and maximise shared learning.
188. Membership of the West Yorkshire Consortium of Local Safeguarding Children Boards ensures access to high quality policies and procedures. They are constantly being reviewed and updated in response to changing legal and other requirements and lessons learnt from practice in Calderdale and elsewhere. For example, in response to the learning from the SCR on Child J, the procedure on missing children has been amended to ensure that information about children looked after who are absent is also shared with other professionals.

189. Having identified the low number of private foster placements as a concern, the LCSB organised an advertising campaign to raise public and professional awareness of private fostering. While it was successful in prompting one notification, more needs to be done to increase reporting and strengthen the local authority's response to private fostering arrangements to ensure that it is meeting its statutory responsibilities so that children are safeguarded effectively.
190. A range of multi-agency training courses and events, which are aligned to the Board's priorities, are being delivered. However, the Board is well aware that it needs to do more to evaluate the impact and effectiveness of the training provided. The absence of a comprehensive multi-agency children's workforce strategy with clear standards and expectations means that the LSCB is not yet in a position to ensure that all of those involved in working with children and families are suitably trained and competent, nor that training resources are being targeted appropriately.
191. Although short on performance data, the 2013–2014 Annual Report is reflective and self-critical. It recognises the previous lack of focus, robust scrutiny and critical challenge and the need to work differently in order to improve outcomes for children and young people and ensure that they are effectively protected and safeguarded at every stage of their 'journey'.
192. A group of Young Advisors, paid by the Board, have helped to make the LSCB website more accessible. They have also been involved in designing a series of 'Shocking Facts' posters on topics identified through discussion with other young people and the results of the eNHA survey. The first poster produced is on children missing from home or care.

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

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