Kirklees

Inspection of services for children in need of help and protection, children looked after and care leavers

and

Review of the effectiveness of the Local Safeguarding Children Board[1]

Inspection date: 12 September to 6 October 2016

Report published: 25 November 2016

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

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

Executive summary

Services for vulnerable children in Kirklees are inadequate, due to serious and widespread failures which result in some children not being protected or having their needs met. Although senior managers and councillors are aware of the inadequacies and have implemented an improvement plan, this has yet to result in sufficient improvements to the experience of vulnerable children in Kirklees. During the inspection, inspectors identified concerns in many of cases that they scrutinised, due to inadequate actions currently being taken by the local authority to safeguard and promote children's welfare.

In August 2015, the chief executive was alerted to concerns about social work practice by the Kirklees Safeguarding Children Board. As a result, he commissioned an external review of services, and this identified serious concerns. An internal audit was then undertaken of 226 cases, approximately 10% of the cases open to the service at the time, and this found widespread poor practice, including for some children where urgent action was then taken to safeguard them. In response, the chief executive recruited an interim assistant director, appointed a new director for children and young people, and established a multi-agency development board to lead the improvement journey.

Since the new director assumed her post in April 2016, there have been considerable efforts to accelerate the improvement of children's services by extending the membership of the development board to include regional partners and establishing a children's scrutiny partnership. Senior management-chaired panels have been introduced to improve decision making at key points. A quality assurance framework has been developed, more independent reviewing officers and child protection chairs appointed and a dispute resolution process implemented to identify concerns. Much work has also been put into developing performance data, practice standards and a workforce strategy, including tackling some individual poor practice. The council also committed an additional four million pounds to children's services.

However, at the time of the inspection, many of these recent developments have yet to be embedded and are not yet making a sufficient difference to children's experiences. Many strategies are in draft form. Inspectors found that they could not trust the performance information being produced. The quality assurance framework has yet to be rolled out. The electronic recording system – which underpins the work of the social workers – is not fit for purpose. Support to staff is inconsistent. For instance, many are not receiving an induction, training or supervision. Across the service, caseloads are inconsistent and, for some workers, too high.

As a result of the improvement focus by the new director and the new senior management team over the past five months, over 500 children, who had been subject to a child protection conference or a child looked after review during this time, were identified by the new dispute resolution process as receiving a poor service. However, when issues have been identified, the responses have not always

addressed the concerns in a robust manner, resulting in some children remaining in unsafe environments or in situations where their needs were not being met.

The local authority has not systematically assured itself, in all cases open to it, that children are safe and are being provided with services that meet their needs and this is a major weakness in the plans to improve services in Kirklees. Inspectors found that many children continue to receive a poor service in Kirklees. There are considerable issues in relation to the help and protection services, with too many children not having their needs met and actions being taken to protect them being seriously delayed. This is due to serious deficits in social work management and practice. Assessments and plans are often poor, failing to recognise risk. Decision making to ensure that children are safe are inconsistent, leaving some children not safeguarded. Multi-agency meetings are not taking place and there is too much focus on the parents, rather than on the experience of children. Children are not always visited by social workers at the timescales identified in their plans.

Services for children looked after are also inadequate, due to serious and widespread issues. Inspectors saw delays in removing from home children who were not safe and poor court work that failed to provide the evidence to ensure that children at risk of significant harm were then placed in safe environments. There is a lack of support services for children on the edge of care. Inspectors also saw far too many children placed a long distance from their communities due to a lack of foster and residential homes in the borough. Children's and young people's concern about being away from their family and friends features in some complaints, which are not being responded to in a timely manner. Too many children subject to a care order are living at home with their parents without a plan for permanence, and this has been ongoing for years – up to 10 years, in a small number of cases. Children wait too long for independent visitors.

In some aspects of children's services, there have been marked improvements following review and robust management action. Due to an improved focus on securing permanence, the use of adoption and special guardianship orders has appropriately increased, although there are still delays for some children. The recording of decision making and ensuring learning from adoption breakdowns need further improvement. Support to care leavers has also improved, but more work is needed to ensure that there are sufficient personal advisors to improve pathway plans and independence support, and to address the high numbers of young people who are not in employment, education or training.

Multi-agency partnership working is poor. Partner agencies have not been sufficiently involved in the multi-agency safeguarding hub. The strategic response to child sexual exploitation is good, although potential risk factors are not always recognised by social workers and other professionals. The Kirklees Safeguarding Children Board had not been aware of the significant inadequacies in children's services or provided sufficient challenge to the effectiveness of safeguarding in the local area. Corporate parents do not yet have sufficient oversight of looked after children's services, due to

poor performance information and insufficient participation by children and young people.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates five children's homes. Four were judged to be good or outstanding at their most recent Ofsted inspection.
- The last inspection of the local authority's safeguarding arrangements/ arrangements for the protection of children was in November 2011. The local authority was judged to be good.
- The last inspection of the local authority's services for children looked after was in November 2011. The local authority was judged to be good.

Local leadership

- The director of children's services has been in post since April 2016.
- The chair of the Local Safeguarding Children Board has been in post since April 2010.

Children living in this area

- Approximately 98,350 children and young people under the age of 18 years live in Kirklees. This is 23% of the total population in the area.
- Approximately 19% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 20.1% (the national average is 15.2%)
  - in secondary schools is 19.6% (the national average is 14.1%).
- Children and young people from minority ethnic groups account for 32.6% of all children living in the area, compared with 21.5% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Asian or Asian British and people of mixed race.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 27.5% (the national average is 20.1%)
  - in secondary schools is 21.6% (the national average is 15.7%).

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

Child protection in this area

- At 31 March 2016, 2,522 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 2,613 at 31 March 2015.
- At 31 March 2016, 415 children and young people were the subject of a child protection plan. This is an increase from 343 at 31 March 2015.
- At 31 March 2016, nine children lived in a privately arranged fostering placement. This is a decrease from 10 at 31 March 2015.
- Over the last three years, 14 serious incident notifications have been submitted to Ofsted and five serious case reviews have been completed or are ongoing at the time of the inspection.

Children looked after in this area

- At 31 March 2016, 652 children were being looked after by the local authority (a rate of 66 per 10,000 children). This is an increase from 620 (63 per 10,000 children) at 31 March 2015.
- Of this number, 277 (or 42.5%) live outside the local authority area
  - 70 live in residential children's homes, of whom 47.1% live out of the authority area
  - two live in residential special schools,[3] both of whom live out of the authority area
  - 444 live with foster families, of whom 42.3% live out of the authority area
  - 64 live with parents, of whom 15.6% live out of the authority area
  - four children are unaccompanied asylum-seeking children.
- In the past 12 months:
  - there have been 42 adoptions
  - 38 children became subject of special guardianship orders
  - 231 children ceased to be looked after, of whom 3.5% subsequently returned to be looked after
  - 47 children and young people ceased to be looked after and moved on to independent living
  - three children and young people ceased to be looked after and are now living in houses in multiple occupation.

[3] These are residential special schools that look after children for 295 days or fewer per year.

Recommendations

1. Take urgent action to ensure that all children currently being provided with a service are safeguarded and their welfare is promoted.

2. Ensure that all staff, including agency staff, are supported to have more consistent relationships with children and to deliver high-quality services through manageable caseloads, induction, supervision and training.

3. Ensure that concerns identified in the dispute resolution process are dealt with promptly and comprehensively, including by independent reviewing officers and child protection chairs.

4. Improve the timeliness and quality of response to complaints from children and their families, including disseminating the learning.

5. Ensure that robust performance data drives improvements in the service.

6. Fully embed the quality assurance framework across children's services.

7. Ensure that the procured electronic recording system is fit for purpose and supports improved practice across the whole service

8. Improve the oversight and challenge of the corporate parenting board by ensuring the availability of robust performance data, and that children's views influence the focus and decision making of the board.

9. Ensure that all assessments and plans focus on reducing risk and improving children's outcomes, with clearly defined timescales for actions, responsibilities and regular review.

10. Ensure that assessments consider the needs of all children in a household and that records of this work are unique to each child.

11. Ensure that the children and young people are visited within the timescales identified in the plans and that, when appropriate, children are seen alone.

12. Ensure that all partner agencies are sufficiently involved in the multi-agency safeguarding hub information sharing and decision making, and that thresholds are consistently applied.

13. Ensure that the services for children who are subject to domestic abuse give robust consideration to safeguarding issues. This is to include consideration and recording of risks identified in multi-agency risk assessment conference meetings.

14. Ensure that child protection strategy meetings involve relevant agencies, that plans are made together and that actions are recorded.

15. Ensure that all child protection conferences are held to statutory timescales and that planning meetings, including core groups and child in need meetings, are held as required.

16. Ensure that the responses to pre-birth concerns are timely and robust.

17. Develop edge of care services and ensure that timely support is available in a crisis.

18. Ensure that, when children need to become looked after, this is actioned promptly, to include improving the quality of pre-proceedings letters to parents, clear contingency planning and ensuring robust monitoring of cases in pre-proceedings.

19. Review all arrangements when children are placed with parents to ensure that these are appropriate and that children are not unnecessarily made subject to a care order.

20. Increase the availability of local placements to ensure that children and young people do not need to be placed at a distance from their communities.

21. Ensure that children looked after have access to an independent visitor when they need one.

22. Continue to improve adoption services for children, to include improving the timeliness of decision making, recording a clear rationale for decisions made and using the learning when adoption placements breakdown.

23. Improve care leaver support, through ensuring that children all have a personal advisor from their 16th birthday and that they have sufficient support to live independently.

24. Robustly address the high rate of care leavers who are not in employment, education or training.

25. Improve access to therapeutic and mental health support for children looked after and care leavers.

26. Improve the quality of pathway plans to ensure that they underpin high-quality support packages.

27. Ensure that there is a robust needs analysis to underpin strategic planning and commissioning of services for children.

Summary for children and young people

- Inspectors found that many services for children in Kirklees are poor.
- Sometimes, when you need to be protected, you do not get the right levels of support to help you when you need it. Sometimes, your parents do not get the assistance that they need quickly enough to assist them with their problems. Social workers, police, schools and doctors do not always work together well enough to support your families.
- Social workers take too long to decide if it is best for you to become looked after, leaving some of you unsafe at home. When you do become looked after, you often need to live many miles from your home, meaning that you do not get to see your family, friends and pets when you would like. Also, plans to help you if you are looked after are not good enough to make sure that you get all the support that you need.
- Generally, when you are looked after, you live with people who understand and meet your needs well. You get good support from health services. You are also now doing much better at school, and more of you gain five good GCSEs.
- The new leaders know what needs to change and are working hard to improve services for children. Some things are starting to improve, such as the support for children who need permanent alternative homes and the support for care leavers, but other changes are needed urgently.
- More of you are now being adopted, although some of you still wait too long for a family. If you are adopted, you and your new family receive good support that helps you to settle in well.
- If you are a care leaver, the local authority is in touch with you, knows where you are living and what you are doing. This means that it can continue to offer you the help and support that you may need. Most of you who leave care, including those of you with a disability or learning difficulty, are helped to find decent housing and to settle in. More of you are staying with your foster families. However, there is not enough help to support your emotional health and you do not always get the right services to support you into adulthood. Too many of you are not being supported well enough to achieve your potential.

The experiences and progress of children who need help and protection	Inadequate

There are serious and widespread failures across the services that provide help and protection in Kirklees. Inspectors identified concerns in over a third of children's cases looked at, including unrecognised neglect and abuse. Much of the social work support is poor, including inadequate assessments, decision making, planning and management oversight. As a result, some children are not having their needs met and are remaining in high-risk environments for too long, and there are serious delays in actions being taken to protect them. Although urgent concerns are, in the main, dealt with promptly, many of these should have been actioned earlier, when lower-level concerns were first identified.

Early help services are too focused on the needs of parents, particularly when there are concerns about domestic abuse. Thresholds in the early help services and the multi-agency safeguarding hub (MASH) are not applied consistently, resulting in some children not being assessed or receiving a service when they should. Some partner agencies are not part of the MASH, resulting in a lack of thorough consideration of all of the needs of children and young people. Plans are in place to extend the MASH to include a wider range of multi-agency partners.

Child protection enquiries are initiated promptly and concerns are appropriately escalated. However, strategy meetings do not always have sufficient contributions from other agencies and fail to plan to take actions together, resulting in a lack of focus on protecting children.

Social work support is not focused sufficiently on reducing risk for children and young people. Many assessments are over-optimistic about parents' ability to sustain changes. Children's individual needs are not always recognised.

Multi-agency planning is poor. Core groups and 'Child in Need' planning meetings are regularly delayed and, at times, do not take place. Only 50% of initial child protection conferences are convened within statutory timescales. Visits to children are not always made within the timescales identified in plans. Management challenge is neither sufficiently robust nor making a difference for children.

Social workers and other agencies do not always recognise potential risks in relation to child sexual exploitation. However, when concerns are identified, there is a good multi-agency response to support the children and young people.

Some aspects of the work are good. Children who are privately fostered are helped effectively. Support is good when there are concerns about radicalisation and violent extremism. Young people who are missing from home receive a timely and independent return home interview. The local authority designated officer also

provides a coordinated response when there are concerns about professionals who work with children.

Inspection findings

28. There are serious and widespread failures in the services for children who need help and protection. As a result, many are not having their needs recognised promptly or essential support put in place. Inspectors saw some children not being protected from further incidents of significant harm.

29. Children in Kirklees are not supported effectively by early help services. Assessments carried out within early help services often lack analysis and are not risk focused. At times, workers have not recognised the need to step up increasing concerns to social care. For instance, some children who are affected by domestic abuse are left at risk due to too much focus on parental issues. Some children are not being seen to ensure that they are safeguarded. (Recommendation)

30. When cases meet the threshold for referral to children's social care, the response by the multi-agency safeguarding hub (MASH) is not sufficiently robust. Partner agencies are appropriately referring children when they have concerns. However, the decision making within the MASH is inconsistent. Some partner agencies are still to join the MASH, and the lack of capacity in others limits the timely and thorough collation of information. There is also a lack of information requested from services outside of the MASH, such as adult mental health. In many cases looked at by inspectors, the subsequent MASH analysis of information was weak. The application of thresholds by managers is also inconsistent and often too high. (Recommendation)

31. The local authority's most recent data identifies that 39% of referrals are repeat referrals. This is considerably higher than that of comparator authorities, at 22.7%. Inspectors found that children and families did not always have their needs met through the initial response from early help services, the MASH and children's social care, and this resulted in further requests for support. Inspectors also found serious inconsistencies between managers about what should be actioned, and saw examples of the same referral being made a number of times with different decisions being made, and even appropriate actions being over-ruled and cases closed, leaving children in potentially high-risk situations. (Recommendation)

32. Children and families who need support or advice out of hours receive an effective response from the emergency duty service. Visits are undertaken by experienced social workers to assess risk. Appropriate services or intervention are then offered to ensure children's safety. The details of the actions are then passed to the day services to facilitate continuity and information sharing.

33. Not all children in need of a social work assessment receive one. Inspectors saw some children, identified by the MASH as potentially children in need, being inappropriately signposted to the early help services. This included some children with a disability, who are then not receiving the statutory assessment required under statutory guidance. Other children are transferred to the newly formed assessment and intervention teams for a single assessment. Timescales for undertaking single assessments are not informed by the needs of children. Inspectors found examples where assessments were stopped, as they were considerably out of date, with some cases then being inappropriately closed without the presenting safeguarding needs of children and their families having been addressed.

34. Assessments are of varying quality. Most included background data and information gained from other agencies. However, many did not refer to previous history, did not highlight risks and strengths, lacked consideration of the voice and experience of the child, and focused mainly on the adults in the household. This does not ensure that children's needs are known and plans are in place to ensure that they are safeguarded. (Recommendation)

35. Recently, there have been changes made to the structure of teams, enabling children to have a single social worker from assessment until a decision for permanence is made. However, due to the large number of agency staff, many children and families have had changes to their worker. Therefore, children are not building meaningful relationships with these key individuals in their lives.

36. Much of the management oversight of the work of social workers, including evidence of challenge, is lacking. Inspectors saw that this had resulted in delays in ensuring that children are safeguarded. New practice standards have recently been introduced. However, at the time of the inspection, some workers and managers were not complying with those standards. (Recommendation)

37. When children are identified as at risk of immediate harm, strategy meetings are held in a timely manner. However, not all agencies attend and the joint planning between the local authority and the police is poor. Inspectors saw examples of the police and social care visiting the child separately, resulting in children and families having to tell their story more than once and causing them further distress. (Recommendation)

38. When a decision is made that there needs to be a child protection conference, there are often delays. The local authority's own data reports that only 50% of initial conferences are convened within the statutory timescale. These delays mean that children do not always receive a timely response or provision of services to ensure that they are protected. (Recommendation)

39. The proportion of children subject to a child protection plan for a second or subsequent time is reported by the local authority to be 26.9%, which is higher than comparators at 17%. Inspectors found that poor decision making, ineffective challenge at key times and insufficient focus on the child's

experience impacted on the sustainability of any changes. For instance, inspectors found that assessments of parents are often over-optimistic, particularly in domestic abuse situations, including the separation of parents being taken at face value and viewed as permanent, despite previous history indicating that a number of separations have already taken place. The cumulative consequences for the children's well-being have not been considered. (Recommendation)

40. There is an effective advocacy service which supports children and young people to prepare for, attend or be represented at child protection conferences. Child protection advocacy was delivered to 281 young people in 2015–16, and this is good, enabling them to participate and understand what is happening.

41. The voice of the child is absent from most records found on children's files. Many assessments do not look at the individual needs of the children. They either focus on one child and do not consider other members of the family, or assess all the children together and fail to evaluate the individual impact of circumstances. Day-to-day case records are duplicated across all children in the family. Inspectors saw examples of file records for a particular child when there was no mention of that child in the record of the work undertaken. Issues relating to gender, sexuality, place in family and ethnicity are, at times, referred to. However, the impact of these issues is not fully explored. (Recommendation)

42. Children and adult services are actively involved in multi-agency risk assessment conferences, which are primarily focused on those most at risk from domestic violence. These draw upon a range of services for families to support change and reduce risks for children. However, information from these meetings is not present in the social care records. Consequently, risks to children are not always sufficiently clear or addressed. Inspectors did find effective use of and liaison with the parental drug and alcohol service, which supported families to make positive changes. (Recommendation)

43. Inspectors found cases where there were concerns about young people's risk-taking behaviours that had not been recognised as potential indicators of child sexual exploitation and referred to the dedicated team. However, when the risk of child sexual exploitation is identified, children and young people receive effective support. The multi-agency team undertakes risk assessments which are used to identify young people's needs. Intensive direct work takes place at the young person's pace. There is also effective co-working with the police to ensure that disruption activity takes place and that geographical 'hotspots' are targeted. (Recommendation)

44. Children and young people who go missing from home receive a timely and independent return home interview. Workers from the targeted youth support service undertake the visit. This ensures that children have the opportunity to talk through their experience and concerns, with the aim of reducing future risks. Kirklees has developed a 'No Child out of Sight' strategy and multi-agency

approach which bring together all services that have involvement with children who go missing. This includes representations from early years provision, schools and mosques. Children missing from education are tracked and monitored by a discreet service, and no case is closed without a successful conclusion. Work is also undertaken with independent schools to offer support and guidance on attendance management and safeguarding.

45. Young people who present themselves as homeless are receiving an effective service. Young people are offered a 'crash pad' to ensure their immediate safety and, when appropriate, are referred in the longer term to supported independent living facilities. When appropriate, young people are offered the option to be looked after. Inspectors also found effective mediation work for young people to return to and remain at home. These services are a significant improvement on those that were available when concerns were identified through an inspection carried out by Her Majesty's Inspectorate of Probation in 2015.

46. Eight children had been identified as being subject to private fostering regulations at the time of the inspection. They receive a sensitive and supportive service. Further work is ongoing to raise awareness of private fostering among professionals and the communities in Kirklees.

47. Children who are at risk from violent extremism are offered an effective and well-coordinated service. The services available to meet assessed needs range from group work and counselling to one-to-one work. Support is offered to the whole family. Work is also carried out to highlight the issue in schools and communities through a good range of activities.

48. The local authority designated officer robustly coordinates the response by agencies when there are concerns about professionals and those who have much contact with children and young people, putting them at risk. There is good contact with social workers, and records on the children's files demonstrate that the protection of children is at the forefront of decision making.

The experiences and progress of children looked after and achieving permanence	Inadequate

Summary

There are serious and widespread failures in the services for children looked after which have resulted in delays in looking after some children and young people who have been at significant risk of harm at home. Inspectors found poor-quality work, including a lack of edge of care services to support children to remain at home, poorly coordinated work that needed to be completed prior to court proceedings, and inadequate court work that caused delay in ensuring that children were protected and removed to a safe environment.

There are widespread shortfalls in the quality of the current support for children looked after. Poor-quality assessments, care planning and reviewing mean that the needs of children looked after are not comprehensively identified and responded to in a timely way. In the past five months, as a result of improved scrutiny, independent reviewing officers (IROs) have alerted managers to over 400 practice concerns about children looked after, such as not being visited regularly, delays in progressing plans, poor-quality placements and social workers not recognising risk. Inspectors found that the response to these concerns was neither sufficiently robust nor making a sufficient difference to children's experiences.

There are insufficient foster home and residential home placements within Kirklees. This results in too many children being placed over 20 miles from their homes. There has been a significant reduction in placement stability, with increasing numbers of children having three or more placements in the past year. Some children have also been living with their parents for far too long while subject to a full care order: in a small number of cases, this has been for over a decade, indicating long-standing deficits in the quality of support, planning and reviewing. The response to complaints is weak, with some significant delays in addressing concerns. There are also insufficient independent visitors to support those identified as meeting the criteria for the service, but advocacy support is good.

Although some children are still waiting too long to be adopted, mainly due to poor practice in the past, timeliness in the adoption process has improved following a review of adoption services in February 2016. Further work is needed to ensure that the rationale for decision making is comprehensively recorded and meetings take place when there are placement breakdowns to learn the lessons to improve future practice. A recently formed dedicated team is providing good assessment and ongoing support for children subject to special guardianship orders.

Most care leavers enjoy positive and trusting relationships with their workers. They move into good-quality and suitable accommodation, with many staying with their foster carers. However, too many pathway plans are poor, there are delays appointing personal advisors and too many care leavers are not in education, employment or training.

Inspection findings

49. There are serious and widespread failures in services for children looked after.

50. Decisions to look after children have not been made in a timely way, and too many children have remained at risk of significant harm. Opportunities to identify risk and intervene earlier have been missed for many children looked after. Services to support children on the edge of care are underdeveloped and, as a result, children and families have not received the support that they need to prevent situations from worsening and further harm occurring. (Recommendation)

51. There has been significant drift and delay in initiating the Public Law Outline process, and in reviewing and progressing work once pre-proceedings work has formally started. Decisions to initiate proceedings when circumstances for children do not change are inconsistent. In the majority of cases seen, letters to parents are not clear in outlining what needs to change, how and by when, with a clear outline of action to be taken if circumstances do not improve. Examples were seen when care applications were not made, despite clear breaches by parents of the contract of expectations. This has meant that the local authority has not intervened effectively to ensure that children are safeguarded. Prior to the inspection, the local authority recognised these serious weaknesses. Very recent developments include the appointment of a manager and two case workers, the implementation of legal gateway meetings and pre-birth tracking meetings to improve oversight of proceedings and decision making, but these are not yet demonstrating a sufficient impact. (Recommendation)

52. Many pre-birth risk assessments are delayed, meaning that opportunities for planned risk management and work prior to the birth have not been taken. This has resulted in emergency action to remove children into care, which increases trauma for families and has not ensured that the best placements are planned for/matched. (Recommendation)

53. Poor-quality legal preparation by social workers has also meant that robust evidence to support the removal of children from the care of their parents has not always been presented to the courts. Inspectors identified that this has left some children and young people in situations where they were at risk of significant harm. (Recommendation)

54. Care planning is also an area of serious weakness. Assessments for children who are looked after are not updated to reflect changes, current needs and circumstances. This means that plans do not support effective care and placement planning. Consideration of, and plans to meet, children's needs arising from diversity were neither evident nor appropriately considered in most of the cases seen. In particular, issues relating to children's heritage were

missed. In a large minority of cases seen by inspectors, plans were neither evident, completed nor updated in timely way. The authority has developed child-friendly care plans which do describe the child's situation, but do not effectively identify or drive areas for ongoing work or risk management. (Recommendation)

55. In the majority of children looked after reviews, actions have not been effectively reviewed or the timely progression of work been supported. Challenge was not undertaken or effective when required. The local authority has taken action to improve the functioning of the IRO service and has both increased the capacity of and undertaken development work with the service. This has resulted in a marked increase in the use of the dispute resolution process. There were over 400 disputes recorded between April and August 2016 in relation to services for children looked after. These evidenced widespread poor practice across the range of work with children looked after. The local authority's analysis and the cases seen by inspectors identified serious issues, including concerns over unsuitable and unregulated placements, plans not being in place or known by young people, inappropriate support, visiting not in place and review decisions not being completed. Moreover, too many disputes were not responded to or resolved in a timely way, leaving children with their needs unmet. (Recommendation)

56. Too many children and young people have been placed with parents at home while being subject to full care orders. In a small number of cases, this has been for over a decade. The management oversight and review have been ineffective, which means that children have been living without permanence being secured for them for too long. The local authority has recently enhanced the management oversight of children placed at home, and work has been initiated to discharge some of the long-standing arrangements. (Recommendation)

57. Permanence planning is improving. The local authority has introduced a number of management panels to ensure that essential work is now undertaken. This has meant that consideration is now given to permanence for all children and young people in a timely manner. This has resulted in improvements in consideration of adoption for all children. There has been an effective use of special guardianship orders to ensure that children and young people are in permanent placements that meet their needs. A specialist connected persons team has supported this development and there is increasing recognition of guardianship as a viable option for permanence in care planning. Coordinated support to children and families with a special guardianship order is generally good.

58. Current placement sufficiency arrangements are not meeting the needs of all children looked after. A very high percentage – 42.5% (277) – of the looked after population is placed outside Kirklees. Although the majority of children are in placements that meet their needs, where they receive high-quality education, health and care support, some children and young people have raised concerns

about the distance from their families and friends. A placement strategy has not been finalised and a comprehensive action plan to address placement shortfall is not yet in place. (Recommendation)

59. Short-term placement stability has also deteriorated, from 9% at the end 2014–15 to the current performance of 14%, with 89 children having three or more placements in the past year. In those cases seen by inspectors, a lack of, or poor-quality, assessment did not support effective placement planning or matching. Support offered to placements did not meet the level of need in the majority of cases. Since April 2016, the local authority has recognised the need to enhance the in-house placement support service by the recruitment of a psychologist, a psychotherapist, and a child and adolescent mental health services worker. However, to date, referrals to the current service have not been sufficiently timely to support effective work in maintaining fragile placements. (Recommendation)

60. A dedicated family-finding service within the fostering service does undertake persistent approaches to matching children, including those with complex needs and keeping brothers and sisters together. However, delays in initiating the family-finding process and the timeliness of pursuing external placements to meet children's needs were evident in the majority of cases seen.

61. The overall capacity of the fostering service has been reduced over the past year and, despite creative recruitment work, not enough potential carers are being identified and recruited to meet identified need. The fostering service has approved 12 new mainstream foster carers in the past year, and three sets of connected carers. The deregistration of 23 carers has diminished the available pool of carers, even though some of these deregistrations reflect robust reassessments following concerns or complaints. The fostering recruitment strategy over the past year has concentrated on foster carers for all ages, with an emphasis on carers for children over 10 years, as well as supported lodgings and mother and child assessment carers.

62. Foster carers report that they feel well supported by their accessible supervising social workers. They are encouraged to embrace a specific parenting model which focuses on their own innate strengths and skills to cope with challenging behaviour. Carers report success in its use even with their own children, and that it makes them feel more confident and validated.

63. The independent visitor scheme is underdeveloped and does not have sufficient capacity to ensure that all of those who meet the criteria receive this service. Advocacy, though, is accessible and well established for children looked after. There were 125 advocacy referrals between April and June 2016. Young people spoken to in the inspection reported positive views and use of advocates. (Recommendation)

64. Despite the serious weaknesses in social work support and the availability of local placements, most children and young people are well supported to meet

their educational and health needs. A recently established looked after children health team, with nurses integrated into looked after children teams, supports timely initial and review health assessments, dental care and immunisations, including for those children placed out of authority. Initial health assessments are effective in picking up health needs which have not previously been identified, and strengths and difficulties questionnaires are consistently used to assess young people's emotional well-being and identify support options. Although it has been a priority, there has been insufficient progress to ensure that all children and young people are able to access therapeutic and mental health support. (Recommendation)

65. The educational attainment and progress of children looked after aged from five to 16 years in Kirklees are improving. Inspectors saw good support by foster carers, residential homes and social workers. The well-managed virtual school is also ensuring that children looked after increasingly receive appropriate and rapid support to help to overcome barriers to learning. Virtual school support for children looked after in the early years and post-16 is at an earlier stage of development, but work is already in progress to ensure that current school leavers sustain their places in further education. All children looked after aged three and upwards have a personal education plan (PEP), and the attendance of under-threes at an early years setting is monitored.

66. All children looked after are enrolled in school or an alternative provision, with 72% attending Ofsted-rated 'good or better' schools. For those not at good schools, this is often due to a decision not to move a child when approaching the end of a key stage or GCSEs. Close monitoring results in relevant appropriate intervention.

67. Electronic personal education plans (e-PEPS) have a number of good features. The voice of the child is presented well. Also, the use of the pupil premium to support the progress of pupils is robustly identified and clear. However, other sections of the plans are not fully completed or have too little detail for the targets to be clear. The use and close monitoring of the pupil premium through e-PEPs, including ongoing one-to-one support, is beginning to have an impact on closing the attainment gap for this group of pupils. The gap between children looked after in Kirklees and the overall cohort is much less than in other authorities for key stages 1 to 3.

68. The majority of Kirklees children looked after make good progress at school. Pupils at key stages 1 to 4 are generally making good levels of progress, given their starting points. Despite some slight falls in attainment in some areas, for example at key stage 1, outcomes are at or above those for similar authorities and the national average, particularly in mathematics.

69. For the 41 pupils who were eligible to sit GCSEs in 2015, 27% achieved five GCSEs, including mathematics and English, at A* to C grades, which is well above the national rate of 14% for children looked after. Fifty-eight per cent achieved five GCSEs at A* to G.

70. The behaviour and attendance consortium is making good progress in improving attendance and reducing the number of children being educated in alterative provision. Attendance at school is above 90% for the majority of children who are looked after. The exception is for Years 9 and 11, and this is due to complex needs, movement into secure accommodation or pregnancy. At the time of the inspection, 11 children looked after were receiving alternative education. In all cases, the authority makes careful checks on the quality and suitability of the provision, and all provision is registered and monitored.

71. The virtual school has good links with workers in authorities in which children who are looked after out of Kirklees are educated. Performance in school is closely monitored by the Kirklees virtual school. Children out of area have access to a good range of different projects to support their progress.

72. The youth offending team (YOT) has a dedicated team of four social workers to support young people who are looked after and, in the cases seen, clear and effective liaison takes place with the social worker, with a reduction in offending behaviour evident in most of those cases. Where young people have a substance misuse problem, the specialist YOT worker also works directly with them. The YOT reports a good reduction in the percentage of children looked after who are known to them, from 12% to 5.9%, which has been assisted by training with local providers in reducing the criminalisation of young people looked after.

73. Children and young people who go missing are consistently offered a timely return interview, and effective liaison is assisted by the police 'missing' coordinator being located within the children looked after service. When there is a risk of child sexual exploitation, children who are looked after are offered effective support and counselling by a national voluntary organisation.

74. The Children in Care Council is a group of articulate young people. They have been involved in a range of work, including participating in recruitment and offering training for foster carers and staff about being a young person who is looked after. The group that was met by inspectors reported positively on the good support provided to them by the children's rights service, helping them to make a positive contribution in Kirklees.

The graded judgement for adoption performance is that it requires improvement

75. Adoption performance in Kirklees requires improvement. An independent review conducted in January 2016 recommended improvements to the timeliness of decision making for permanence, adopter recruitment and the length of time that children wait to be placed with potential adoptive parents. The authority has prioritised these specific areas and, as a result, there have been recent improvements to the adoption support provided in Kirklees. However, the

impact of these improvements is yet to be embedded, and many children and young people still wait too long to be adopted.

76. During 2012–15, the adoption scorecard shows that children in Kirklees waited on average 635 days from entering care before moving in with their adoptive families. For adoptions in 2015–16, the Kirklees measure worsened to 714 days. The local authority has an understanding of the cases that have impacted on this performance and has identified where improvements are required. The authority has introduced a permanence panel to ensure that timely consideration is given to permanence for all children and young people. Recording of the decision making, though, is not always clear on the child's file, resulting in a lack of clarity in the child's primary records regarding the reasons for that decision. (Recommendation)

77. The number of children adopted from care this year is 49, an increase on the previous year when 45 were adopted. The increase this year is above the national adoption trend and reflects the recent placements of some hard-to-place groups of children, such as the over fives and family groups.

78. The service is effective in placing brothers and sisters together, when assessments recommend that this is the best plan. In 2015–16, 11 groups of brothers and sisters were placed together, and three groups remain in need of a placement. No brother and sister groups were placed separately following an assessment that recommended that they should be placed together. When there are difficulties in finding a local match for a child or a group of brothers and sisters, the adoption service makes effective use of regional consortium links, national adoption agencies and media opportunities to widen the pool of potential adopters.

79. Eight children are yet to be matched with adopters. The authority family finders have broadened searches for potential adopters for these children by linking with a range of external agencies, including a television documentary to be aired in National Adoption Week.

80. The recruitment strategy recognises the need for adoptive families for the growing number of babies and young children identified as needing a permanent placement in Kirklees, as well as placements for older children and brother and sister groups. Regional, national and interagency links are regularly used to widen searches for suitable adoptive parents.

81. Early permanence planning and the possibilities provided by fostering to adopt are being promoted by the recent introduction of specialist family finders from the adoption service who attend permanence planning meetings. Over the past year, 11 children have been adopted through this process, with four more children still in proceedings. This practice creates greater opportunities for children to be placed with their adopters at an early stage and minimises delay.

82. Assessments for prospective adopters are thorough and informed by effective multi-agency collaboration. Adopters who spoke to inspectors reported that the assessment process was well handled, though challenging, and that the adoption workers enabled them to really understand the impact of adoption. There are 14 sets of potential adopters currently waiting to be matched. Links have been made with national networks to ensure that they have access to additional potential matches. The service is reflecting on the learning from assessments of this group of adopters to inform future recruitment targeting.

83. A small number of children have experienced unplanned endings to placements in the past year, yet disruption meetings have still not taken place. Liaison between the adoption service and the reviewing unit has not resulted in arrangements for these meetings. This is a missed opportunity to learn and identify any assessment or matching shortfalls. (Recommendation)

84. The adoption panel meets monthly, is properly constituted and fulfils its role well. The experienced chairs provide scrutiny and challenge which inform the development of improved practice. Approved adopters sit on the panel both to inform about their experiences and provide additional independent scrutiny.

85. Consideration of life after adoption is well organised in Kirklees. Life-story books and later-life letters are started at the earliest opportunity, in the majority of cases. The standard of the work seen was good, with families and foster carers helping to create a portfolio of photographs to create a visual story. They are effective histories to assist children to make sense of the reasons behind the decisions leading to adoption that were taken on their behalf.

86. Post-adoption support for adopted children and their adoptive families is well established, responsive and accessible. A dedicated team develops comprehensive support assessments and coordinates interagency involvement. The adoption support plans seen by inspectors were comprehensive and evaluative, and lead to targeted and effective support that maintains placements. Adoption support is rated highly by adopters and is complemented by accessible further training opportunities. Additional celebration events and peer support groups for adopters and children ensure their ongoing positive relationship with the authority.

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

87. Services for care leavers require improvement. The vast majority of care leavers enjoy positive and trusting relationships with their workers. They move into good-quality and suitable accommodation, with many staying with their foster carers. However, transitions are not planned for in a timely way, and young people do not always have the most focused support to meet their needs.

88. The local authority is increasingly effective in keeping in touch with care leavers, and reports that it is in touch with all but two of its 183 care leavers. Young people who have been placed out of the area also have good contact with the authority, with many supported well to return to Kirklees on leaving care.

89. The majority of care leavers report being well supported by their social workers. Planning for leaving care does take place, although there have been insufficient personal advisors to provide young people with support from their 16th birthday, as identified as necessary in statutory regulations. Recently, care leavers have been allocated a personal advisor within six months of their 18th birthday, and there are plans in place to extend this to meet the requirements in regulations. Care leavers also receive support from a range of other agencies, including housing and health. (Recommendation)

90. Care-leaving staff are particularly skilled in helping young people to understand the potential outcomes of their behaviour, especially in relation to risks, including those that might affect their sexual, emotional and physical health. As a consequence, almost all care leavers who spoke with inspectors have a good understanding of how to keep themselves safe and say that they feel safe.

91. Managers recognise that too many pathway plans are not effective planning tools and often do not accurately reflect the work done to support young people as they leave care. The majority are too descriptive, and are often not fully complete. The education section of most plans is very poor and does not reflect the work now being done by dedicated care-leaver careers advisers. Some of the care leavers who spoke with inspectors could not remember completing a pathway plan, therefore could not comment on its usefulness or otherwise. (Recommendation).

92. The current percentage of care leavers who are not in employment, education or training (NEET) is 47%, compared to 44% in neighbouring authorities. The authority has a clear focus on improving the situation, headed by the EET strategy group. Targeted interventions are now made to engage and sustain young people in education or training. As a result, at the time of inspection less than 10% of this year's school leavers are NEET and their progress is closely tracked. Examples of support include one-to-one advice and guidance sessions, introductions to potential work placements and support to attend college courses. A number of charities and training providers offer foundation-level study programmes for young people age 16 to 18, but provision for young people who are not yet ready for these is limited. Although Kirklees does offer apprenticeships, only two care leavers have taken up the opportunity. (Recommendation).

93. Increasing numbers of care leavers progress to higher education, including to prestigious universities, and achieve good degrees. For the 16 care leavers who are in higher education, a good package of support, including financial and emotional support, is helping them to achieve well.

94. Most care leavers develop good levels of personal independence skills, supported by their carers, social workers and personal advisors. Some care leavers are well supported to develop their independence and self-help skills by access to the care leavers' centre, Young Dewsbury, which is run by the local authority. The centre works effectively in partnership with the local authority. Staff at the centre, two of whom are former care leavers, provide useful and bespoke support, helping young people to develop the skills that they need to live independently, for example budgeting and cooking. Young people can also access help with job search and interview skills, and support with housing and health issues. This support is dependent on where young people live, and not all are able to access the same high-quality preparation for independence. (Recommendation).

95. Care leavers are clear about the range of services and support that are available to them. These are detailed in an informative booklet, partially designed by care leavers, although at the moment it is not available in a suitable format for young people with differing communication needs.

96. Care leavers are routinely provided with useful health information and health passports. Dedicated looked after children nurses are available to provide support, advice and written information. As a result, care leavers are well supported in relation to their physical health. Most care leavers recognise the need to take responsibility for their own health needs. However, a number of care leavers expressed concern to inspectors about their mental health needs not being well addressed. Despite changes to create a single point of access to mental health services, care leavers experience long waits to access appropriate mental health services. (Recommendation).

97. A flexible and individual approach helps to ensure good transition arrangements for those care leavers with an identified and long-standing disability. For the majority, education or training and housing needs are supported well by improving joint working between agencies. A number of care leavers with a disability have been very effectively supported by the 'Shared Lives' team, including a transition into adult care with their foster carers.

98. The vast majority of care leavers live in appropriate housing, and are safely and well accommodated. Other than 10 young people in custody, only one care leaver is in unsuitable accommodation, but this is about to change to a tenancy. The numbers of care leavers who are 'staying put' with former foster carers are increasing slowly, and there are currently 19. Kirklees housing services give priority to care leavers on the housing list and offer support when they bid for tenancies. They provide very effective pre-tenancy and tenancy support to vulnerable young people, especially for those with a disability.

Leadership, management and governance	Inadequate

Summary

Standards of practice since the last Ofsted inspection in 2011 have significantly deteriorated. The chief executive, senior managers and members did not recognise this decline until the end of 2015. External review and a series of audits identified that the scale and scope were widespread, and that services were not effective in protecting children. Despite extensive efforts by leaders, managers and members to improve services since then, there remain many children and young people who are experiencing a poor service because of inadequate social work practice and poor frontline management. Senior leaders have not systematically assured themselves that all children open to children's social care are being effectively safeguarded and their needs met, and this is a major weakness in the plans to improve services in Kirklees.

The new director of children and young people's services took up post in April 2016 and, along with her new senior management team, has focused on building foundations, both for strengthening the line of sight of frontline practice and for good social work to flourish. At the time of the inspection, it was too soon to see much impact from these very recent changes in improving the experience of vulnerable children in Kirklees. The performance data and the authority's electronic recording system are still not fit for purpose. A quality assurance framework has been introduced recently, although is not yet embedded. Increased independent reviewing officer and child protection chairing capacity is improving the oversight of practice, although this is not yet sufficiently improving the quality of social work practice or improving outcomes for children.

Staff stability is a significant challenge, and 25% of the workforce is agency staff. The high turnover of social workers and managers significantly impacts on the quality of services received by children and young people. Overall, the induction, supervision and training of staff are inconsistent, with insufficient oversight and challenge of poor practice.

Operationally, multi-agency planning is weak, including the functioning of the multi-agency safeguarding hub and joint planning for children in need, child protection and children looked after. Risks relating to child sexual exploitation are not always recognised by social workers and other agencies. The Kirklees Safeguarding Children Board and corporate parents had not recognised the widespread weaknesses in the services being provided to many children. The oversight and the involvement of children and young people in the work of both boards are weak.

Areas that have shown improvement as a result of strengthened arrangements include improved permanence planning, adoption, services for young people leaving care and some aspects of the support provided to children looked after.

Inspection findings

99. Standards of practice since the last Ofsted inspection in 2011 have seriously declined. Serious weaknesses were identified by leaders and an improvement plan put into place. Extensive efforts by the new senior leadership team have begun to impact on practice. However, sustained improvements are not evident and many children continue to receive a poor social work service.

100. Practice concerns were identified through a Kirklees Safeguarding Children Board (KSCB) audit in August 2015. However, the extent of these weaknesses was not fully understood at the time. The local authority commissioned an external review across all areas of social work practice. This identified widespread and systemic weaknesses in the help for and protection of vulnerable children in Kirklees. Between February and April 2016, the local authority audited 226 children's files, 10% of those cases open at the time. This identified that 54% of those children had received an inadequate social work service and a small number of children needed urgent action to be taken to protect them. Subsequently, the local authority increased its quality assurance capacity. However it has yet to assure itself systematically that all children open to children's services are safe and their needs are being met.

101. The director of children and young people's services took up post in April 2016. She and her new management team have a clear, long-term vision of services for children and families in Kirklees. Since her appointment, she has extended the work of the development board and worked with neighbouring authorities to assist in developing further capacity.

102. The management team has implemented significant changes, including: a service restructure to increase accountability and reduce the number of changes of social workers children experience; a review of the multi-agency safeguarding hub (MASH) to provide a single point of entry to access social work support; the development of a performance management framework to measure improvement; and the implementation of a refreshed workforce strategy, focused on recruitment and retention. Where the workforce is stable, improving quality is more evident.

103. Governance and accountability have been strengthened by regularly scheduled meetings between the chief executive officer and the independent chair of KSCB, and weekly meetings between the lead member and the director. The new lead member has an improved overview and understanding of frontline practice, not only from the external reviews of service provision but also through chairing the renewed corporate parenting panel and the Children's Trust, as well as attending the Health and Wellbeing Board and KSCB. A new

children's services council scrutiny committee has been introduced. An additional panel for members in relation to child sexual exploitation further increases scrutiny arrangements for some of the most vulnerable children.

104. Workforce instability is impacting on the local authority's ability to sustain service improvements. This is a recent issue and follows the departure of many permanent members of staff in the past year, as a result of some permanent staff exiting due to poor performance and the council's restructuring of its services. The staff turnover rate is 10.9%. However, it is significantly higher in some parts of the service, such as in the duty and care assessment teams. A quarter of the workforce is of agency staff, including social workers, team managers and service managers. Agency workers also provide cover for long-term sickness and vacancies in the workforce. The local authority has experienced a number of agency staff leaving the service, some as a result of poor practice. The local authority has negotiated with social work agencies extended periods of notice to manage this turnover of staff better. Changes in managers, though, have led to inconsistent management decision making and application of thresholds. Young people told inspectors that they found that they were unable to develop positive relationships with their social workers because of changes in staff. One young person told inspectors that they were unhappy about having three new workers in a period of six months.

105. Targeted recruitment activity has led to some recent successful appointments of experienced social workers and team managers through enhanced packages of employment. A new workforce development strategy is underpinned by a set of clear principles to enable social work to flourish, and is accompanied by an appropriately prioritised action plan which includes delivery of a comprehensive training programme. Given its infancy, there has been limited impact. However, newly qualified social workers spoke highly of their protected learning environment within a team of all newly qualified staff. These staff receive good support, including a structured four-week induction, a buddying system with an advanced practitioner and tailored training focusing on core social work skills. Some social workers are now benefiting from smaller caseloads, in particular those who are working with children looked after. The principal social worker's capacity has been increased and there is a renewed focus on back-to-basics training. Inspectors identified a small number of children benefiting from a review of their files by experienced agency staff, with appropriate action then being taken to protect them and meet their needs proactively.

106. The quality and frequency of supervision remain poor. The local authority has recently revised its supervision policy and provided further training for managers. However, the impact of this is not yet evident. Inspectors saw that supervision lacks a focus on children and does not drive forward care planning. Agency staff often do not have supervision. (Recommendation)

107. Poor and inconsistent recording on children's files makes it difficult for managers and newly allocated workers to identify progress and work to be undertaken. During the inspection, social workers and team managers were

unable to locate key documents relating to children, including assessments and plans. Senior managers and leaders have recognised that children's files do not provide good-quality or effective recording mechanisms, and have secured funding to procure a new electronic recording system. (Recommendation)

108. The quality of management grip across children's services varies from poor to adequate. Where the workforce is stable, overall there is adequate management oversight. However, it is significantly poorer in those parts of the service that are experiencing frequent staff changes. Within these areas, inspectors identified inconsistent application of thresholds, risks not being sufficiently identified, explored or responded to and a lack of critical challenge of poor practice which contributed to children receiving an inadequate service.

109. Compliance with practice standards by some social workers and managers continues to be a serious issue for the local authority. To address weaknesses in the identification of risk and inconsistent management decision making, the local authority has established a number of panels chaired by senior managers to ensure a clear line of sight on frontline practice. Inspectors were provided with evidence of improved planning for some children. However, not all of these panels are embedded or effective, such as the pre-birth panel.

110. An increase in the numbers of independent reviewing officers and child protection chairs has enabled a sharper focus on practice. The recent dispute resolution process identified over 500 practice concerns in child protection and looked after children's social work over a five-month period. However, corrective actions have not always been timely, resulting in children remaining in situations where their needs were not met and, in some cases, where they were potentially at risk of significant harm. (Recommendation)

111. During the inspection, inspectors identified many cases where they had serious concerns and referred back 100 of these to the authority for urgent review and further actions to be taken. The individual response to these was robust, for the vast majority. However, inspectors were concerned that the local authority has not proactively assured itself that all children and young people whom they are working with are safe and that their needs are being met. The local authority's own audits, the dispute resolution concerns, and the sampling and tracking done by inspectors demonstrate that the risks to a significant number of children who are currently being provided with a service remain unknown and unexplored. (Recommendation)

112. The local authority has invested significantly in developing a comprehensive quality assurance framework that was launched during the period of inspection. Performance information is provided on a whole-service and team basis to identify some key areas of underperformance. However, the poor quality of data drawn from the electronic recording system inhibits the local authority's priority to establish an effective performance culture. For example, managers are unable to report accurately on children being seen and they do not have confidence in the management information produced, but instead develop

manual systems to help them to understand performance. Inspectors found the quality of data the performance data produced by the local authority to be unreliable, with serious deficiencies in its accuracy. (Recommendation)

113. Recently established performance clinics provide day-long monthly meetings when data is scrutinised and lines of enquiry explored. A review of each area of service is undertaken by the assistant director, with appropriate challenge evident. This is helping to improve accountability for poor performance. However, the local authority does not yet have a good understanding of the reasons for some performance outliers, such as the 48% increase in children subject to child protection plans and the increase in children becoming subject to plan for a second or subsequent time. (Recommendation)

114. The local authority does not meet its sufficiency duty. There are too many children and young people living at a significant distance from Kirklees, away from their friends and families. The joint strategic assessment and local authority needs analysis lack depth in profiling and understanding the needs of children looked after. A commissioning cycle is not yet established. (Recommendation)

115. Agencies work well together at a strategic level. This is evident in the commitment to improving services to help and protect children by way of the development board and sessions between community safety partnerships, Kirklees Adult Safeguarding Board, KSCB and the Health and Wellbeing Board, which have identified cross-cutting themes and priorities such as female genital mutilation. The Health and Wellbeing Board has focused on some areas of children's commissioning. This includes a recent child sexual exploitation commissioning strategy which contributes to the police's and crime commissioner's planning across the region. However, there is more to be done operationally to ensure that agencies understand their responsibilities in relation to contributing to good-quality assessments and planning for children, recognising risks in relation to child sexual exploitation, and information sharing and decision making in the MASH.

116. Corporate parents had not recognised the extent of the concerns until February 2016 and, despite positive action being taken now to address this, the corporate parenting board remains underdeveloped. Performance information is not sufficiently developed to provide robust oversight, facilitate effective challenge or drive improvements for children and young people. Young people have not sufficiently participated in the board meetings and it is unclear how they are influencing its priorities. (Recommendation)

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is inadequate

Executive summary

Kirklees Safeguarding Children Board (KSCB) is judged to be inadequate, as it is not discharging all of its statutory functions as outlined in 'Working Together 2015'. In particular, some partner agencies are not members of the board.

The KSCB has not fully recognised the extent of the improvements required across the partnership. The frequency and impact of its auditing activities have not responded sufficiently to the serious and widespread issues in children's services. Consequently, the board has not monitored the extent of the difficulties or provided systematic and independent scrutiny and challenge.

The KSCB has not progressed serious case reviews and actions to improve practice in a timely manner. The child death overview panel has also delayed analysing all local child deaths.

The multi-agency performance data that the KSCB receives is poor and there are significant delays in partners contributing data. The KSCB has not systematically tracked or analysed emerging patterns and trends over time. It has not been sufficiently challenging of partners, resulting in inconsistent chairs and participation in workstreams. This has impacted on the quality, consistency and pace of progress.

The KSCB has not had sufficient oversight of all vulnerable children to understand the effectiveness of safeguarding practice across the partnership in relation to specific cohorts of children identified in the national guidance as needing to be considered by Local Safeguarding Children Boards.

There are insufficient multi-agency trainers, and the voice of children and young people is underdeveloped in driving improvements in the board's work.

The board has now a revised child sexual exploitation strategy and action plan outlining the need for improvements in key areas of preventing, identifying and responding to children at risk. However, there remain issues about all professionals in agencies recognising indicators and risk factors relating to child sexual exploitation.

Recommendations

117. Ensure that all partner agencies participate in the working of the Kirklees Safeguarding Children Board (KSCB) to improve safeguarding across Kirklees.

118. Ensure that the board has routine reporting and monitoring arrangements for all groups of vulnerable children, specifically the effectiveness of services for children with disabilities, those who are young carers, those living out of the area, and those receiving services and interventions within the 'Prevent' programme.

119. Secure meaningful and timely multi-agency data, with supporting analysis, to ensure that the board maintains effective oversight and monitoring of children's experiences of safeguarding and the effectiveness of services.

120. Ensure that there are effective and consistent arrangements for chairing the child death overview panel (CDOP), addressing the causes of delays in considering child deaths, and that accurate and timely data is available, with analysis, to inform the CDOP annual report.

121. Fully develop ways to involve children and young people, including children looked after and care leavers, across the business of KSCB.

122. Improve the quality of serious case review (SCR) action plans and robustly address delays in progressing SCR action plans.

123. Ensure that there is a sufficient pool of multi-agency trainers to deliver the training programme, and that analysis takes place to identify its impact on improving services.

124. Ensure that all agencies recognise the indicators and risks factors relating to child sexual exploitation.

125. Ensure that there is a full programme of multi-agency audit activity.

126. Improve the quality of the KSCB annual report to demonstrate that the board has an ongoing analysis of the performance and effectiveness of local services, and the reasons for any emerging patterns or trends.

Inspection findings – the Local Safeguarding Children Board

127. The board has lacked understanding of the extent of the serious and widespread weaknesses in children's services and has provided insufficient challenge to the local authority over the inadequacies found during this inspection. The independent chair of KSCB has been in post since 2010 and reports previous complacency across the partnership in holding children's services to account. Following a peer review and the commissioning of an external consultant, shortfalls were identified in the board's work. As a result,

some aspects have improved. However, not all requirements set out in 'Working Together 2015' are met.

128. Most significantly, the board has not been sufficiently challenging of partners and their responsibilities to safeguard children in Kirklees, which has resulted in inadequate progress in some highly concerning areas. Serious case review (SCR) action plans have not been progressed in a timely way. There have been delays in progressing reviews of child deaths and ensuring that national guidelines are met. Multi-agency performance data is insufficient to provide an overview of the quality of safeguarding practice. There are also serious discrepancies between partner agencies that have actioned board priorities within their own organisations.

129. The KSCB has not had an overview of all vulnerable children, for example children identified as young carers, children with disabilities, children looked after placed out of Kirklees and children for whom there are concerns about radicalisation. Neither has the board had full sight or influence of early help developments until recently. This is now a priority within the business plan for 2016–17 and a focus for a workstream to progress an agreed strategy and implement the vision for early help and prevention. The board has led a review of thresholds in consultation with partners, which has led to a revised continuum of needs and responses document that was launched in August 2016. This is in the early stages, and is yet to be well understood and consistently applied across the partnership. (Recommendation)

130. Not all partner organisations are involved in the KSCB. There are educational settings not represented on the board, namely mainstream schools, colleges and faith organisations. There is now a representative from the voluntary sector after a short gap in attendance. Positively, two consistent lay members are active members of the board and provide an independent perspective from the local community. (Recommendation)

131. Some children and young people have been involved in board activities such as the section 11 audit challenge day, interviewing board members and facilitating workshops at a conference for practitioners. However, the board has identified the need to be more inclusive of children's and young people's influence across its priorities. This extends to existing groups such as the Children in Care Council and care leavers, who are not currently consulted and involved, despite their well-informed perspectives. (Recommendation)

132. Following the peer review in 2015 and work by an external consultant in 2016, there has been extensive and ongoing activity to refocus the priorities of the board through a revised business plan for 2016–17. All the key strategies and frameworks have been reviewed in recent months and, overall, are clear working documents. The KSCB website is accessible, with good links to all KSCB business. A 'challenge log' has been developed and completed retrospectively. The board itself has action plans to improve how the board structures its workstreams and membership and focuses on its priorities. However, there

continue to be difficulties in securing consistent chairs for some workstreams, for example evaluation and effectiveness, learning and development, and the CDOP. This continues to impact on the progress made. (Recommendation)

133. SCRs are initiated and reports are published on the KSCB website. Since January 2016, one SCR has been published, and another has been completed and is awaiting a publication date following the completion of criminal proceedings. A further SCR has been commissioned. The national panel did not agree with the KSCB recommendation not to carry out a SCR, and this has prompted the board to revisit this case. Overall, there have been some lengthy delays in progressing actions. The quality of SCR action plans contributes to these delays, as some actions are not specific with clear timescales. The dissemination of learning by KSCB organisations has also not been sufficiently rigorous, and implementation and progress have not been monitored. (Recommendation).

134. The multi-agency performance data that the KSCB receives is poor, and there are significant delays in partners submitting the required data. This is impacting on how soon the board has sight of data. For example, the data for 2015–16 is not yet complete. This limits the board's ability to identify emerging trends and how well children's needs are met. The patterns and trends over time are not analysed sufficiently to understand any changes, influences and then how best to provide challenge. This limits the quality of the annual report, with the most recently published report for 2014–15 containing very little analysis of the effectiveness of child safeguarding. The board is now working to agree a smaller, core dataset across the partnership to focus on key areas of performance to facilitate better oversight. This is work in progress, as is improving the KSCB annual report for 2015–16, which is in draft form and lacks sufficient consideration of key safeguarding issues. (Recommendation)

135. The board has a programme of auditing activity, but this is limited by the majority of the audits being undertaken in single agencies then collated into overall findings. This misses the opportunity to understand and learn the multi-agency lessons from collectively analysing practice and focusing on the same children and families. This approach also reduces the shared scrutiny and challenge element, as the method relies on self-assessment. The quality of auditing activity is neither consistently nor sufficiently focused on the outcomes for or impact on children and families. Nor are practitioners and managers involved in auditing, which misses this connection with frontline practice and the opportunity to strengthen learning. There are also challenges in partner agencies' identification of representatives for auditing activity, which continues to delay planned audits. The KSCB undertook a small audit of cases in which children experiencing neglect had delays in being allocated a social worker. This audit appropriately identified concerns in August 2015, and the report was presented at the next board in December 2015. The board did not undertake further activity to assure itself of the extent of the issues for children and revise its strategy for oversight and monitoring. (Recommendation)

136. The KSCB initiated a review of children and adolescent mental health services in September 2015 to understand a child's journey from a safeguarding perspective. This was initiated due to concerns raised at the board by partners and reported locally. There have been delays in progressing this, but it is very recently concluded and is awaiting a final report.

137. The KSCB has a revised child sexual exploitation strategy and action plan, following a further external review which outlined the need for improvements in key areas of preventing, identifying and responding to children at risk. This area of work was underdeveloped across the partnership, and the action plan outlines a clear direction in which to make improvements in line with national learning. Although, in the main, the work to address child sexual exploitation is robust, there remain serious deficits in professionals' recognition of these issues within cases. During 2016, the board also recognised the need to improve its oversight of children missing education, of children who are home educated and of unregulated schools. (Recommendation)

138. In the past 12 months, the KSCB's training programme has been developed and now offers a comprehensive range of training to support the workforce with key areas of safeguarding. The e-learning packages are well promoted as part of the training offer. There are flexible options, such as lunchtime seminars and separating full days into manageable half days. However, there are ongoing issues with poor attendance, which the board has begun to prioritise and raise with partners. The actual number in the pool of trainers has been insufficient. For example, when the key post-holder was absent for four months, very little training took place. The quality and impact of some training are evaluated. However, improvements are needed in analysing the impact of training. For example, 18% of respondents can identify how practice has improved from SCR learning, but there is no evaluation from the majority of 82% who did not comment. (Recommendation).

139. Arrangements to review child deaths are inadequate. The arrangements for reviewing child deaths are shared with a neighbour authority, as are the chairing arrangements. A recent decision has been made to review deaths of babies of under 23 weeks gestation, in line with national guidance, as this was not happening. The quality and analysis of data for the CDOP are poor and are not systematically collated throughout the year, and the figures for 2015–16 are still being analysed. At the point of this inspection, the reviews of 35 deaths are not yet concluded. Fifteen of the 35 deaths were notified prior to 2016. In 11 of the 15 cases presented to the panel, it was determined that further information was required before conclusions could be drawn. (Recommendation)

140. The chair meets regularly with the chief executive, the director of children's services and lead members to share information. The chair is included on the local authority's development board to link closely with the improvements that the local authority is striving for. The KSCB has formalised links with the Safeguarding Adult Board and the community partnership board in the last year through 'three-board' meetings and development days. This liaison has resulted

in agreeing and developing agreed strategies for tackling female genital mutilation, reducing incidents of child sexual exploitation at all ages and delivering early help for all ages. These are recent developments and are to be tested for operational impact. Further developments are underway to extend work with the Health and Wellbeing Board and the Children's Trust.

141. Procedures are written and updated by a private company, and these are of a good quality. The board audits compliance through section 11 audits every 18 months. The last audit, in August 2015, added specific questions on child sexual exploitation. Agencies' responses were tested through panels at a challenge event. Positively, this included a young person's panel, with prepared testing questions and contributions to the feedback. From this, agencies were asked to devise child sexual exploitation action plans, although the quality of these varied. Due to capacity, the board has not been able to follow through when responses were not sufficient, for example when key agencies answered 'Not applicable' to key questions.

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 and two additional inspectors.

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