Halton

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: 18 November 2014 - 10 December 2014

Report published: 3 February 2015

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

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

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

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

Contents

The local authority

Summary of findings

Children's services in Halton require improvement because:

Consistency of practice

- The quality of plans, including child in need, child protection, care, pathway, and personal education plans, is not yet consistently good. Plans are not always clear about actions, objectives and timescales and are not always written in plain English. This limits the local authority's ability to drive improved outcomes and measure progress for children and young people.
- Almost half of social work single assessments require improvement to be good. Although risk and protective factors for children are identified, they are not routinely analysed to consider the impact on children and young people or to help future planning.
- Not all children who go missing from home receive a return interview and in some cases where they do, the record of this does not influence planning and decision making in a timely way.
- Until very recently, assessments have not consistently been completed in a timely manner. Very recent improvements, although significant, need to be maintained.

Management capacity and oversight

- The re-shaping and re-focussing of services put in place by the Strategic Director and his senior leadership team is not fully embedded and services are not yet consistently good
- A lack of sufficient management capacity within the Contact, Assessment and Referral Team (CART) has contributed to delay in a minority of cases when progressing contacts to a referral for a social work assessment. The rationale for management decisions taken is not always clearly recorded. This means that for some children, assessments of need and risk are delayed and can lack focus.
- The high caseloads of the independent chairs of child protection case conferences limit their ability to monitor the progress of child protection plans between conferences. Independent Reviewing Managers (IRMs) have caseloads significantly in excess of statutory guidance. This limits the quality assurance of children's plans.
- Management oversight of the pre-court proceedings process is not sufficiently robust. As a consequence, a few children have experienced quite substantial delays before agreed action has been taken.
- The fostering recruitment strategy fails to set targets for recruitment and the local authority does not have a thorough understanding of the type of placements it needs. This restricts the choice of placement and matching and increases the

reliance on independent fostering agencies.

Educational Outcomes

- The role of the Headteacher of the virtual school in challenging as well as supporting schools is not fully understood. There is more work to do to ensure that secondary schools are fully held to account for the achievements, attendance and rates of fixed term exclusion in their schools.

Children and young people's participation

- Young people's involvement in the child protection process is under-developed, including the take-up of advocacy, which has been poor. Arrangements to involve young people in the corporate parenting partnership board are new and not yet fully embedded or effective.

What does the local authority need to improve?

Priority and immediate action

1. Improve the quality of planning for children (child in need, child protection, care, pathway and personal education plans) to ensure that all plans are timely, prioritise key issues and enable parents, carers, children and young people to understand what needs to be achieved to improve children's and young people's safety, well-being and educational achievement.

2. Ensure that all children and young people who go missing from home and care have a return home interview, and that information is made available to relevant professionals in a timely manner to inform risk assessment, management and planning.

3. Strengthen management oversight and capacity within the CART to ensure that referrals progress in a more timely way to children's social care, and that decision making with regards to thresholds is consistently clear and robust.

Areas for improvement

Consistency of practice

4. Ensure that single assessments consistently provide analytical evaluation of risk and protective factors and are informed by good quality chronologies.

5. Strengthen the consistency of core groups in analysing the impact of actions on intended outcomes.

6. Improve the quality of child permanence reports in order that matching is robust and a child's history is clearly recorded.

7. Ensure that fostering records reflect thorough consideration of matching needs, including how any gaps will be met.

Management capacity and oversight

8. Ensure that records of strategy discussions consistently include SMART actions and contingencies.

9. Ensure that the independent chairs of child protection case conferences have sufficient capacity to monitor the progress of plans between conferences and to distribute the minutes of conferences in a timely fashion.

10. Ensure that management oversight of the pre-court proceedings process is sufficiently robust to avoid unnecessary delay within this process.

11. Review the capacity of the Independent Reviewing Managers team to ensure that it is sufficiently resourced to meet its statutory responsibilities and revise the escalation policy to ensure that challenge is recorded and that responses and actions are timely.

12. Strengthen the capacity of commissioned services to provide direct work to children and adult victims of domestic abuse, focusing on the impact of domestic abuse on children and young people.

13. Revise the fostering and adoption recruitment strategies to ensure that targets are set to match local need and to provide a sufficient number and range of placements.

14. Ensure that young people who life-story work need receive it in a timely way.

15. Ensure that awareness raising of private fostering is sufficiently targeted within communities and amongst those working with children and families, and that it links to existing work on child sexual exploitation (CSE).

Educational outcomes

16. Further develop the role of the headteacher of the virtual school to ensure that secondary schools are held to account fully for the attainment and progress of their children in care, and for reducing the number subject to fixed period exclusion.

Children and young people's participation and access to information

17. Strengthen the participation of children and young people within child in need and child protection processes, in particular, their attendance at child protection core groups and conferences and their take-up of advocacy services. Gather feedback on their experience of such processes to help make improvements in the quality of practice.

18. Establish effective arrangements to ensure that the views and experiences of the children in care council (CiCC) influence and inform the work of the corporate parenting partnership board.

19. Ensure that all care leavers are aware of their right to access health information about themselves and to health passports.

The local authority's strengths

20. Early intervention in Halton is increasingly effective in supporting children and families whose assessed needs fall below the threshold for social work intervention. This is supported by a strong Inspiring Families programme (Troubled Families), effective children's centres (seven out of eight of which are graded good by Ofsted) and a well-embedded common assessment framework (CAF).

21. The local 'Levels of Need Framework' is well understood by social workers and partner agencies, and provides a good foundation for understanding and applying consistent thresholds for decision making.

22. In the vast majority of cases, child protection concerns are dealt with swiftly and effectively when they are identified. Child protection conferences are held promptly to tackle concerns about children at risk of significant harm.

23. Social workers visit children regularly, carry out direct work with them to understand their wishes and feelings and, in a large majority of cases, build good relationships with them that support improved outcomes.

24. The local authority considers adoption for all children for whom it might be appropriate and these children go on to move in to their adoptive families quicker than children in similar local authorities. Adopters say that they are well prepared and supported by the local authority.

25. Halton is better than similar local authorities at keeping in touch with care leavers, ensures that they have appropriate accommodation, and supports a higher percentage of them into employment, education and training. This includes six (10%) at university and four included within the local authority's 11 'traineeship' posts.

26. The local authority and its partners have been proactive in tackling CSE. Awareness-raising publicity, a well embedded risk assessment tool and strong commissioned services are in place to support young people. Audits of practice and a joined up front-line approach all sit under the umbrella of a pan-Cheshire strategy. An updating review of work in this area was taken to full council on 10 December 2014, and plans for a dedicated multi-agency CSE team are well advanced.

27. Good inter-agency working in Halton is exemplified by the very high quality children's joint strategic needs assessment (JSNA), which is focused, detailed and up-to-date and which clearly informs the priorities within the children and young people's plan.

28. A strong commitment from the chief executive and political leaders has been central to embedding a 'whole-authority' approach to improving outcomes for children in Halton.

29. Commissioned services are well targeted on identified priorities, and intelligent contract specification and management ensures that services provide value and are responsive to changing need.

30. Social workers in Halton are capable and committed and are well supported, with regular reflective supervision and a comprehensive package of training and development opportunities.

Progress since the last inspection

31. The last Ofsted inspection of Halton's safeguarding arrangements and services for looked after children was in February 2011. The local authority was judged to be good for both services. The last unannounced inspection of contact, referral and assessment was in December 2011. Three strengths and three areas for development were identified.

32. Although progress has been made in some areas, there remain some recommendations from those inspections that have not yet been fully met. These include: ensuring that assessments and plans are consistently good; ensuring that the minutes of child protection case conferences are distributed promptly; ensuring that young people who have been looked after receive a record of their health histories; and reducing high caseloads (this remains the case for independent chairs of child protection case conferences and IRMs). Improvement in these areas remains as a recommendation from this inspection.

33. The local authority has made strong progress against recommendations to improve the quality of supervision, which is now good.

34. The local authority's fostering service was inspected in July 2012 and was judged to be good. The recommendation to implement an effective fostering sufficiency strategy made following that inspection remains a recommendation from this inspection because insufficient progress has been made. The lack of sufficient local authority foster carers does not however impact negatively on children and young people because the local authority makes up for this shortfall through the use of agency foster carers.

35. The local authority's adoption service was inspected in October 2013 and was judged to be adequate. The authority has made good progress against the majority of the eight areas for improvement identified at that inspection. However, the quality of child permanence reports remains variable, and recommendations made in 2013 to ensure that information relating to brothers and sisters and family health histories are in reports is still not being consistently achieved. Improvement in this area remains as a recommendation from this inspection.

36. The pace of change and improvement has been notable within the period covered by the inspection (the last 12 months). Prior to this, service improvements and developments have been more limited in their impact, with some of the recommendations from the last full inspection in 2011 remaining incomplete. The Strategic Director and his senior leadership team have provided strong leadership in re-shaping and re-focusing services to better meet the needs of children in Halton. Although recent improvements need to be embedded and practice is not yet consistently good, positive change is seen in increased child protection and looked after children numbers that more accurately reflect need within Halton. Services are increasingly timely and of improving quality. The direction of travel towards good services is in place.

Summary for children and young people

- Senior staff in schools and health services told inspectors about positive improvements to the system used when they report worries about a child or young person's safety to the local authority. They usually get told quite quickly what the local authority has done to make sure these children or young people are safe. Occasionally there are delays by the local authority in using the information to make decisions. This is something we have asked the local authority to improve.
- The local authority's plans for children in need of protection, personal education plans, care plans and pathway plans for care leavers are usually detailed. However, they do not always explain clearly enough the actions that will be taken or the difference these actions will make to improving things.
- Services and agencies across Halton are working well together to help children and families when they are just starting to have problems. This means the problems can be tackled successfully before things get to a crisis point. They also work well together when children or young people might be unsafe, and almost always take action quickly.
- Social workers are very committed to helping children and protecting them from harm and they know them well. They make sure that they visit children who are on child protection plans and children in care regularly. They speak to them and see them alone to help them to share their views.
- Social workers say that they enjoy working in Halton and are well supported. They receive good training so that their skills are up to date and they know how to offer good support to children. Managers check social workers' work regularly, but not all managers check to see how well the work with young people is going, if it is making a difference or if they need to do anything differently.
- Adoption services are doing a good job and there is an increasing choice of adopters for children in need of adoption.
- Children in care in primary schools attend school regularly and do well. This is not always the case in secondary schools, and more needs to be done to make sure that children in care in secondary schools do well too.
- Care leavers who spoke to inspectors are very positive about the support they get, including the support to help them find the right college, training or work. This support ensures that a high proportion of care leavers are in education, training or jobs. However, although care leavers receive this good support, it is not always part of their pathway plans and these plans need to be better.

Information about this local authority area[3]

Children living in this area

- Approximately 27,950 children and young people under the age of 18 years live in Halton. This is 22% of the total population in the area.
- Approximately 26% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in nursery and primary schools is 31% (the national figure is 17%)
  - in secondary schools is 29% (the national figure is 15%).
- Children and young people from minority ethnic groups account for 3% of all children living in the area, compared with 22% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are White and Black Caribbean and White and Asian.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 1% (the national figure is 18%)
  - in secondary schools is 1% (the national figure is 14%).

Child protection in this area

- At 18 November 2014, 1,107 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 1,146 at 31 March 2014.
- At 18 November 2014, 222 children and young people were the subject of a child protection plan. This is an increase from 164 at 31 March 2014.
- At 18 November, no children lived in a privately arranged fostering placement. This is the same position as 31 March 2014.
- Since the last inspection three serious incident notifications have been submitted to Ofsted and no serious case reviews have been completed or are on-going at the time of the inspection.

Children looked after in this area

- At 18 November 2014, 231 children are being looked after by the local authority (a rate of 83 per 10,000 children). This is an increase from 211 (75 per 10,000 children) at 31 March 2014. Of this number:
  - 77 (or 33%) live outside the local authority area

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

- 31 live in residential children's homes, of whom 87% live out of the authority area; three children live in residential homes with a residential school
- 149 live with foster families, of whom 19% live out of the authority area
- 21 live with parents, of whom 5% (one child) lives out of the authority area
- 3 children are unaccompanied asylum-seeking children.

- In the last 12 months (to 18 November):
  - there have been 16 adoptions
  - 18 children became subjects of special guardianship orders
  - 85 children ceased to be looked after, of whom 8% subsequently returned to be looked after
  - 5 children and young people ceased to be looked after and moved on to independent living, including one living in a house of multiple occupation.

Other Ofsted inspections

- The local authority operates 2 children's homes. Both were judged to be good or outstanding in their most recent Ofsted inspection.

Other information about this area

- The Director of Children's Services has been in post since December 2006.
- The chair of the LSCB has been in post since January 2014.

Inspection judgements about the local authority

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

Summary

Too many contacts within Halton's Contact, Assessment and Referral Team (CART) take too long to progress to a referral to children's social care, including a small number of children who are at risk of significant harm. This is largely as a result of insufficient management capacity and oversight within the CART. The management rationale for decision-making within the CART is not always clearly recorded, including some decisions which are subsequently changed as a result of the quality assurance processes.

The quality of assessments and plans is too variable. Too many assessments lack a clear analysis of risk and need, and too many plans lack clear objectives to help parents and carers understand what needs to change and why.

Quality assurance via tracking and audit is yet to be fully embedded across children's social care. In particular, child protection chairs lack sufficient capacity to track the progress of child protection plans and challenge drift and delay where necessary.

Most children who go missing from home quickly receive an independent return interview that is used to help plan for their future safety. A few children do not receive an interview, have to wait longer for it, or their interview is not used to influence planning and decision-making.

Multi-agency responses to CSE focus well on prevention and are responsive to local intelligence. Direct work with young people is helping to reduce risk in most cases.

The local authority cannot be assured that children who may be privately fostered are safe and well cared for.

Early intervention in Halton is increasingly effective in supporting children and families whose assessed needs fall below the threshold for social work intervention. The local Levels of Need Framework provides a good foundation for all agencies to understand and apply consistent thresholds.

The local authority has been successful in ensuring that very few children are missing education or persistently absent from school. It provides effective support to schools and is effective in ensuring that children and young people who are educated at home or in alternative provision are safe and receiving an appropriate education.

Social workers know the children and families they work with well; they are committed and are supported through regular, reflective supervision and training.

37. The Local authority's 'Early Help Strategy' was launched in April 2013, alongside the revised 'Levels of Need Framework'. The Contact Assessment and Referral Team (CART) was established in September 2013. Intensive and family support services were re-aligned to form three locality Early Intervention Teams from September 2014. Weekly 'locality working together' meetings take place in Runcorn and Widnes which bring together agencies effectively to discuss referrals for early help. The delivery of early intervention services is increasingly successful in tackling issues before they become a crisis.

38. The number of CAFs completed has stabilised following a period of decline, with 248 open at the end of October 2014. Most CAFs are of a good quality, showing timely actions from the range of agencies needed to support children and improve their outcomes. The quality and impact of CAFs is monitored regularly by a multi-agency quality assurance group, and outcomes are reported to senior managers and used to drive improvement where weaknesses are identified. The CAF is used effectively to support children and families who have been stepped-down from a child in need plan. The majority of cases that need to be stepped-up to a child in need plan when more complex or serious issues emerge are considered in a timely manner. The development of the CART has been a positive step for Halton and is well regarded by partner agencies in providing a single point of access to early help and children's social care. The more recent inclusion of CAF Support Officers within the CART has strengthened the gathering of information on cases assessed to be in need of early intervention.

39. The Inspiring Families programme in Halton has a clear, positive impact on the lives of 275 out of the 375 families (73%) it has worked with. This activity has been integrated successfully into the Early Intervention Teams.

40. Halton children's centres are at the heart of the early help strategy and provide a range of services, such as parenting interventions, supported by the co-location of health visitors. Multi-agency Team Around the Child (TAC) or CAF meetings are regularly conducted within children's centres, which provide a non-threatening and child-centred environment for families. All but one of the eight children's centres in Halton have been judged good following their Ofsted inspections and all are noted for their partnership working. The Children's Centres Improvement Plan for 2014–15 supports a co-ordinated approach to their work, but does not provide sufficient clarity about how they will engage with and improve outcomes for children subject to child in need or child protection plans.

41. Too many contacts made to the CART are held as a contact for too long and do not progress to referral for a social care single assessment in a timely manner. Whilst the majority of cases are appropriately progressed to a referral within 24 hours and assessed by Child in Need Teams, a significant proportion (around 20% of cases seen by inspectors) do not progress quickly enough. This means that for some children, assessments of their needs and risks are delayed. In a small minority of cases, decisions to progress to child protection investigations

did not therefore occur within 24 hours of the original concern being notified to CART. Despite these delays, inspectors did not see any evidence that this resulted in immediate harm to a child. The delays are mostly due to lack of sufficient management oversight and capacity within the CART. The local authority is aware of this shortfall and is planning to strengthen these arrangements.

42. The CART received a total of 1,387 contacts between 1 July and 30 September 2014, 27% of which were from the police. 12% of all contacts to the CART were in respect of domestic abuse. There were too many delayed notifications by the police to the CART, and therefore some children living within households with domestic violence are not being assessed quickly enough.

43. Referrals to the CART from other agencies are mostly appropriate and of good quality. Effective information sharing arrangements support decision making. A wide range of agency checks are undertaken by social workers within the CART and, where appropriate, consent is obtained from parents. Information gathered within the CART, including family histories, is used to inform decisions about levels of need and risk. All decisions within the CART are taken by an experienced and qualified social work manager. However, the rationale for management decisions is not always clear and well recorded. Decisions about contacts and referrals are routinely reviewed at a weekly multi-agency referral meeting, which provides an effective opportunity to quality assure practice and to review thresholds. However, when original decisions are changed as a result of assessment or new information, this has not always been recorded appropriately or in a way that enables a transparent understanding of the reasons. The local authority took prompt action to change this practice when alerted to it during the course of the inspection.

44. The number of child protection enquiries undertaken has risen significantly. In the vast majority of cases, strategy discussions are timely and the majority take place between social care, police and health. However, a third of records of strategy discussions seen by inspectors did not include the recording of timescales for completing actions or contingencies in the event of those actions not being progressed. Child protection enquiries are conducted by suitably qualified social workers and appropriate action is taken to protect children at risk of, or who are suffering, significant harm.

45. The quality of single assessments remains variable, with 44% (8 out of 18 seen by inspectors) judged to require improvement to be good. All assessments include a list of risk and protective factors, but some are too descriptive and fail to analyse information sufficiently or give adequate weight to the impact of these factors upon children. A few poorer assessments do not consider the role of fathers or other significant family members.

46. Local authority data for July to September 2014 shows that only 65% of children were seen within five working days of the start of an assessment. Performance in more recent months has significantly improved, but the authority will need to make sure that this recent improvement is maintained

and that a focus is kept on completing assessments in the right timescale for the needs of each individual child.

47. For a small number of children, assessments do not lead to the timely arrangement of child in need meetings. This results in delay in co-ordinating the support needed to meet complex needs or reduce risks. Chronologies do not always go back far enough to include sufficient history of significant events and are not always kept up to date. This means that they do not inform assessment and decision making as well as they could.

48. Risk assessment within Halton is well embedded within social work practice. A range of risk assessment tools are used to inform decision-making. Assessments do not however always make clear how they inform decision-making. Young people's views are not always recorded within such assessments. In the majority of cases, authoritative and timely action is taken where the risk of harm remains or intensifies.

49. Direct work with children and young people to ascertain their views, wishes and feelings is recorded in the vast majority of cases, and includes the use of various tools. Inspectors saw some excellent examples of how younger children's wishes and feelings had influenced assessment and decision making. Most social workers know the children they work with well and demonstrate a good understanding of the children's needs and circumstances. They are mostly well supported through regular, reflective supervision and training and are highly committed to outcome-focused practice. In one team, frequent changes of social worker have, until recently, hindered the development of more effective and meaningful relationships with a small number of children.

50. A range of services are provided to meet the needs of disabled children, for example, the Positive Behaviour Support Service, which provides specialist interventions to children, young people and adults with learning disabilities and autistic spectrum conditions. Strong partnership working with adult services and well-defined packages of care, including the provision of a high quality short-break service, enable young people's needs to be met as they move into adulthood.

51. The vast majority of Child Protection Conferences are timely, with 97% of reviews taking place within the statutory timescale. Over 50% of child protection plans relate to neglect, which reflects the focused management attention on this issue during the past 12 months. A significant proportion relate to emotional harm due to domestic violence. There has been a rise in the number of children subject to a child protection plan for a second or subsequent time. Attendance at child protection conferences is mostly good, but improvement to the engagement of GPs in the process has not been effectively sustained. Core groups take place regularly and are well supported by partner agencies. Inspectors saw some strong social work practice within a core group, for example, difficult and challenging messages being conveyed to parents in a sensitive manner. Core groups do not consistently evaluate the impact of previous recommendations and actions to assess progress. The

distribution of minutes from child protection conferences and core groups is not yet consistently timely.

52. The quality of planning is not yet consistently good. Just over half of child in need plans and child protection plans lack clear timescales and objectives, have a tendency to be formulaic and are not always written in plain English. Child protection plans, in particular, do not routinely explain for parents what professionals are concerned about, what needs to change and how this change will be measured. The local authority has recognised this and, from September 2014, has used a 'windscreen' tool, which helps to visually illustrate concerns for parents. This is a very new development and its impact is yet to be evaluated.

53. Children and young people's participation in meetings is not well developed. Very few young people attend child protection conferences. The local authority has recently changed arrangements for advocacy. It is now to be 'opted out of' rather than 'opted into', but it is too early to evaluate the impact of this.

54. The local authority demonstrates a good understanding of the number of child protection plans where domestic violence, parental drug or alcohol misuse or mental ill-health is a risk factor. In November 2014, 101 child protection plans out of 222 had one or more of these features. The local authority uses this data to inform commissioning and service planning, for example, the commissioning of a service to support victims of domestic abuse. However, the capacity of this well-regarded service is increasingly under pressure, which means that the service is not able to effectively engage in all review processes concerning children and adults with whom they are working.

55. The number of children subject to a child protection plan has significantly increased in the last 12 months, from a comparatively low baseline, due in part to the impact of the neglect strategy. This has placed considerable pressure on the Safeguarding & Quality Assurance Team, which has led to an additional child protection chair being appointed. However, child protection chairs continue to have very high caseloads, which exceed 100 cases. This significantly restricts their capacity to track and monitor the progress of child protection plans between reviews. An escalation process is in place and this has led to Child Protection Chairs effectively challenging delays in the timely progression of actions, but this is not consistently leading to the prevention of drift and delay in all cases. For example, a lack of effective tracking has meant that a small number of children subject to child protection plans have experienced significant delays when decisions have been made to escalate cases to the pre-court proceedings process.

56. A range of actions have been taken to reduce the proportion of children in need persistently absent from school. According to local authority data, this has significantly reduced to 6.3% from 21% in 2012/13. The proportion of children identified with special educational needs is reported to have risen to 30%, which is now in line with similar local authorities. Work to narrow the gap in terms of the educational achievement of children in need at Key Stage 4 has

not had sufficient impact to date. Good, well-established partnership arrangements are in place to identify, track and meet the needs of pupils at risk of exclusion from mainstream education provision. Currently, there are 81 young people in alternative provision, the vast majority of whom are placed within provision which has been quality assured by the local authority. There are currently only 6 children missing out on a school place, all of whom have been missing for a very short period and have plans in place to address this. The local authority and its partners proactively monitor and review these arrangements. Good systems are in place to track, and check the safety and achievements of 41 children currently home educated. The designated local authority teacher ensures that families are visited as soon as possible following their request, and no child is taken off the school roll until the teacher has checked the safety and educational arrangements.

57. Arrangements to identify, track and respond to children who go missing from home or care are mostly effective. The local authority works closely with the police and a voluntary sector organisation (Catch 22) to ensure that there is good understanding of the 'push and pull' factors associated with missing episodes. 'Safe and well checks' are conducted by the police and information sharing with schools is proactively managed through 'Operation Encompass'. Staff demonstrate a good understanding of the relationship between going missing and child sexual exploitation, and this is managed well at a strategic level under the leadership of the LSCB. Targeted work has been successfully undertaken with local children's homes through 'Operation Arundel', which ensures a co-ordinated approach to young people who are more vulnerable to going missing. In October 2014, there were 19 missing episodes from care involving 11 young people, and 18 missing episodes from home involving 14 young people. At the time of the inspection, there were no young people missing for more than 24 hours. Good collaborative working and the use of a tracking system lead to risk management meetings being convened when a child is missing more than five times within a 90-day period. However, these meetings are not always informed by a documented return home interview and some social workers are not able to clearly explain how information from these interviews is used to plan how children will be kept safe in the future.

58. Multi-agency arrangements in respect of child sexual exploitation are well developed, supported by a pan-Cheshire strategy; this is actioned, planned and driven by the LSCB to tackle the recognition and prevention of CSE, and ensure a co-ordinated response to young people assessed to be at most risk. Preventative awareness-raising has taken place within schools and a communication campaign, 'the more you know, the more you see', has successfully raised awareness of CSE. Targeted work aimed at disrupting potential offending activity has taken place in response to local intelligence. An operations group meets regularly to discuss children who have been referred following the completion of a CSE screening tool, and to share local intelligence. Commissioning arrangements with Catch 22 have been extended to include direct work, consultancy to practitioners and training to the children's workforce and other groups, such as hoteliers and licenced premises. An audit of practice

across partners has recently been undertaken, with a further 'deep-dive' audit planned in early 2015. The outcome of a strategic review in the light of Professor Jay's Report (on CSE in Rotherham) was presented to a meeting of the full council on 10 December 2014, and plans to establish a multi-agency dedicated CSE team in 2015 are well advanced. Currently, no children are assessed as being sexually exploited, although active risk management plans are in place for 12 young people deemed to be at risk of CSE.

59. A range of agencies support the work of the Multi-Agency Risk Assessment Conference (MARAC) for medium and high risk victims of domestic violence. Monitoring of the performance of MARAC indicates that a low proportion of referrals (28% between 1 July 2013 and 30 June 2014) were from agencies other than the police, which is well below regional, comparator and national averages. The consistency of the local authority's involvement has significantly improved since January 2014; MARAC is now supported by two practice leads from the child in need teams. Risks to victims and children are appropriately assessed and this informs decisions about actions needed to ensure their safety. However, greater rigour and management oversight is required to ensure that all information is acted upon in a timely manner by social workers.

60. Effective arrangements are in place to assess 16- and 17-year-olds who present as homeless to services in Halton, and no young people are placed in bed and breakfast provision.

61. There are currently no children or young people who are known to be privately fostered in Halton, and historically numbers have been low. Awareness-raising activity has not had sufficient impact during the last 12 months. This raises concerns that there are more children whose circumstances are not known, and who are therefore potentially vulnerable. The local authority is aware of this issue and has recently taken steps to re-invigorate the work of the private fostering group under new leadership, and plans to refresh its action plan.

62. The arrangements for the management of allegations by the Local Authority Designated Officer (LADO) are effective and well regarded by partners such as schools, which also benefit from good support from the Safeguarding Children in Education Officer. Timely meetings are arranged in the majority of cases to respond to concerns or allegations about people who work with children; these include representatives from appropriate agencies including the employment sector in which the subject of the concern or allegation works or volunteers. Actions are SMART, with clear timescales and the majority are progressed in a timely way. The LADO is supported by a bespoke database which helps to monitor and track the progress of cases and convene reviews where necessary. In 2013-14, a total of 32 cases progressed to a LADO meeting, and 100% of those cases that concluded during the year were resolved with 3 months.

63. There are some strong examples of children, young people and family's participation in helping Halton to continuously improve its services, through groups such as Halton Children's Trust Advisory Group (INVOLVE), Halton Family Voice, which provides a forum for parents to influence services, and

Halton Speak Out – Bright Sparks Project, which supports young people with additional needs to share their views and ideas about the services provided to them and to be involved in decision making. However, collating feedback from children, young people and families who have been involved in child protection processes is less embedded, and is an area for development acknowledged by the local authority.

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

Summary

The local authority is a committed corporate parent to the children and young people in its care. The large majority are visited regularly by dedicated social workers who know their children and young people well and understand their needs. Social workers in the children in care and care leavers teams have manageable caseloads and are supported by regular supervision and good training. Staffing pressures in one team led to an unacceptable number of changes of worker for a small number of children. The local authority knows this and has taken to steps to improve the situation.

All of the children and young people's case files seen by inspectors had care plans. They are regularly reviewed by Independent Reviewing Managers (IRMs) and the records of review meetings are written in a child-friendly manner.

Court proceedings in Halton are completed quicker than in other local authorities so that children have permanent plans for their future agreed in a timely manner.

Improvements have been made in the timelines of initial health assessments when children first become looked after, and the vast majority of children and young people are registered with a dentist and have had their immunisations.

The attainment, attendance and progress of primary school-aged children in care is good. Positive action is taken to ensure that children in care attend good or better schools. Although improving, the attainment of children in care at the end of Key Stage 4 is still not good enough.

The large majority of foster carers spoken to by inspectors are very positive about the experience of fostering for Halton. However, the authority fails to set targets for recruitment and does not have a thorough understanding of the type of placements it needs. This restricts the choice of both placement and matching options and increases the authority's reliance on independent fostering agencies (IFAs).

Adoption performance is good due to the thorough preparation, assessment and support of adopters, effective family finding for children waiting for adoption and collaborative working with neighbouring authorities.

Personal advisers have strong relationships with care leavers. The majority of who are well prepared for, and successfully move on to, independent living. Good support ensures a higher proportion of care leavers successfully access education, training or the world of work.

64. There has been a year-on-year increase in the number of children and young people looked after in Halton. In November 2014 there were 231 children and young people looked after, compared with 145 at 31 March 2013 and 124 in 2011–12. Despite this considerable increase, inspectors did not see any children or young people entering care who should not have done so. The number of children looked after is now in line with similar local authorities. This situation is indicative of the improvements made in the past year by the senior management team.

65. Good support ensures that very few children who return home after a period of being looked after become looked after for a second time. Only seven out of 231 children looked after in November 2014 were in care previously; none of these children are under the age of 11.

66. The Designated Judge for Cheshire and Merseyside and the Children and Family Court Advisory and Support Service (Cafcass), both report that the threshold for issuing care proceedings in Halton is appropriate. In 2012–13 the average time taken for court proceedings was 40 weeks, reducing to 32 weeks in 2013–14. In August to October of 2014, the average time was 24 weeks, which compares well with the national average of 30 weeks. Communication between family court advisors and IRMs on individual cases is good.

67. At just over 8% in 2013–14, the percentage of looked after children who experience three or more placements remains slightly better than the most recent published figure for similar local authorities (11% in 2012–13).

68. The local authority is making increasing use of special guardianship orders (SGOs) to secure children and young people's future. Of the 35 children who ceased to be looked after in the six months prior to the inspection, more than a third (13) were made the subject of a SGO. This is a significant increase on five children (13.2%) in 2012–13. In four cases seen by inspectors, assessments and decision making in relation to seeking SGOs was timely and had led to good outcomes for children who are able to stay in the care of their extended family. However, in two cases there was some delay, as foster carers were not initially asked whether they would wish to continue caring for the children in their care when the plan for adoption was changed. Practice has since changed to ensure that foster carers are now considered at an early stage in these circumstances.

69. The large majority of children and young people's records show that they are seen regularly by their social worker and, when talking to inspectors, social workers clearly knew and understood the needs of the children they work with.

70. Social workers say their caseloads are manageable and inspectors saw caseloads which ranged from 15 to 23. However, staffing pressures in one team have led to a very small minority of children experiencing an unacceptably high number of changes of social worker. This has had a negative impact on their

ability to develop a relationship with their social worker and on the planning and progress of their care.

71. Care plans are in place and most are sufficiently detailed, although a minority lack sufficient clarity about actions, objectives and timescales. Children and young people's contact arrangements, together with health and leisure needs are considered in looked after children's reviews and are reflected in children's plans. Not all children, especially older children in foster care, receive life story work as soon as they need it.

72. IRMs meet children before reviews, and review notes are written in a child-friendly manner. The increase in the number of children and young people looked after in Halton has put pressure on the IRM service. Currently IRM caseloads are in the high seventies, which is higher than that recommended within statutory guidance. Capacity problems have not yet had a negative effect on the IRMs' ability to conduct reviews and track progress, but have contributed to a backlog in distributing notes of review meetings. The local authority is aware that if caseloads continue to increase, the IRMs will have insufficient capacity to meet their responsibilities fully. Inspectors have seen evidence on children and young people's files of IRMs tracking progress and challenging decisions. However, the escalation policy needs to be revised to ensure that challenge is accurately recorded and that responses and actions always happen in a timely manner.

73. Positive action is taken to ensure that children in care attend schools judged by Ofsted to be good or better, and 87% of children in care attend such schools, compared to just fewer than 80% of children in Halton as a whole. Careful pre-placement work between the headteacher of the virtual school and social workers ensures that the best provision is secured. This is also the case for children in out of borough placements. When children are already placed in schools that do not maintain their good grade at inspection, the headteacher of the virtual school visits the school and evaluates the quality of provision for the child and makes a balanced risk assessment as to whether it is in their best interests to move them. This is good practice.

74. The attainment of primary school children in care is good, and has been so for the past three years. Eighty per cent of pupils gained Level 4 or above in reading and mathematics tests in 2014. The gap between their achievements and other pupils in Halton is lower than that of similar pupils and their peers nationally: the gap in Halton is 19% whilst the most recent data indicates the gap between children in care and their peers nationally is 31%. Year 6 children in care make better than average progress from their starting points at the age of seven than other pupils in Halton, and than similar pupils nationally. This is not the case in secondary schools, where progress is below average from their starting points at the beginning of Key Stage 3.

75. The attainment of children in care at the end of Key Stage 4 is still not good enough. The proportion gaining five good GCSEs including English and mathematics for the three year average from 2011 to 2013 was 29%, much

higher than the national average of 15%. However, no children in care achieved this in 2013 and only 11% in 2014. Every effort is taken to meet the complex needs of some pupils who enter the care system in Year 10 or 11, but actions taken have not always had enough time to help pupils catch up from a very poor starting point.

76. Good actions by the headteacher of the virtual school, education welfare officers and schools are helping to ensure that children in care attend school regularly. The most recent local authority data shows that over 98% of primary-aged pupils attend regularly; above that of all pupils in Halton and the national average. There has been a slight dip in the attendance rate in secondary schools to 86%, which is lower than the Halton and national averages. The overall absence rate of 4% for children in care compares favourably to that found nationally at 5%.

77. No children in care have been subject to permanent exclusion since 2008. Significant individual work and support is carried out by the headteacher of the virtual school and her team, alongside support services in the local authority, to help pupils to remain in school and learning. The proportion subject to fixed term exclusion remains broadly average. No children in care are missing from education and all attend their full entitlement. Eight are in alternative provision that is quality assured by the local authority and schools, whilst an additional five are in good quality out of borough placements, four of whom have been placed at short notice after coming into care in an emergency.

78. The headteacher of the virtual school and her team provide ongoing support and interventions to schools, and are particularly commended by headteachers for their direct or commissioned work for children in times of acute need. The local authority provides an extra personal education allowance for children in care, in addition to that provided by the government's pupil premium fund, and this is used to provide direct one-to-one support, activities or equipment to children in school. Detailed recording of this work shows the rich variety of support provided. However, current tracking does not always measure the impact of such interventions.

79. The local authority is aware that personal education plans (PEPs) require improvement to be good, and has developed a new process that is rolling out from September 2014. Those seen by inspectors were of variable quality, with just three out of 14 being good. Academic targets are not often specific enough about what children need to do to move on and some targets are not challenging enough; two were seen where the target for the end of the year had already been met in the autumn term review, with no further stretch target for the end of the year having been added. Headteachers report that the system is cumbersome, and a consultative group has recently been set up to make sure that PEPs are fit for purpose.

80. The headteacher of the virtual school is well known by headteachers, but her role in challenging as well as supporting schools in not fully understood. There is more work to do to ensure that secondary schools are fully held to account

for the achievements, attendance and fixed term exclusion of looked after children in their schools. There has been little recent training for designated teachers but this is being re-instigated with a conference shortly to help ensure that designated teachers are accountable to the headteacher of the virtual school for the schools' work with children in care.

81. Low numbers of children and young people are placed more than 20 miles from their home when compared with other similar local authorities. Secure arrangements are in place for sign-off of decisions to place children and young people out of the local authority area. Detailed forms are completed by social workers and signed off by the Operational Director or Strategic Director.

82. Children and young people who live away from their home authority have immediate access to education and health services to meet their needs. Placement agreement documents signed off by senior managers describe how needs will be met. Staff in three children's homes out of the area confirmed to inspectors that relevant information was provided to them in a timely manner in almost all cases to ensure that there is no delay in meeting children's educational and health needs. However, in one case, where the child had had a number of changes of social worker, not all documents were provided in a timely way.

83. Children and young people know how to complain and have access to independent advocates. Twenty-eight looked after children contacted the advocacy service between April and October 2014. An example was seen by inspectors where a young person contacted the advocacy service directly and the problem they raised was quickly resolved. In another case, a young person placed outside the local authority area is using the advocacy service to challenge contact arrangements about which they are unhappy. Ten young people are currently being visited by an independent visitor and three young people are waiting to be matched. Thirteen volunteers are currently completing training as independent visitors before being available to be matched with children.

84. In all cases seen by inspectors, good attention was given to supporting children to access a range of leisure activities, including cubs, drama, sports, a music project and the canal boat project (a social inclusion project). The recent introduction of a free swimming pass for all carers and looked after children was initiated by the children in care council (CiCC) and is welcomed by young people and carers. The local authority is currently piloting a gym membership scheme for young people.

85. Improvements have been made to the timeliness of initial health assessments; 96% of children are registered with a dentist and 97% are fully immunised. Review health assessments are still not sufficiently timely, at 72%.

86. Go4ward is a dedicated service for looked after children and young people who have emerging mental health needs. The service is run by Barnardo's and works directly with children and young people and their carers. Until recently

there was no waiting list for this service, but the increase in the number of children and young people looked after has increased the pressure on the service. The local authority is aware of this and substantial investment has been made in the new contract, which is currently out to tender, to increase the capacity and extend the offer.

87. Where young people go missing or are at risk of sexual exploitation, multi-agency risk management meetings are held to consider and address risk. In one example seen by inspectors, thorough consideration was given as to how to reduce risk from missing episodes, including the consideration of secure accommodation. Catch 22 has continued to work with that young person, despite them being placed away from the local area and beyond the 30 mile catchment area serviced by Catch 22. Although return interviews are almost always carried out records of these interviews are not always received by social workers or copied into case files. This limits the extent to which they can inform planning to keep children and young people safe in the future.

88. Foster carers who spoke to inspectors were almost all entirely positive about the experience of fostering for Halton. They value the support and training provided and they have delegated authority for the children they care for.

89. During April to September 2014 a total of 86 initial enquiries about becoming foster carers were received, with 32 people attending information sessions and 15 progressing to Skills To Foster training and assessment. During this period, nine new households have been approved but six households have had their approval terminated, which gives only a slight increase to the overall availability of placements. The fostering recruitment strategy fails to set targets for recruitment, and the local authority does not have a thorough understanding of the type of placements it needs. This restricts the choice of placement and matching and increases reliance on independent fostering agencies.

90. Records do not always reflect the quality of family finding and matching that takes place within the fostering team.

91. Six young people from the children in care council (CiCC) spoken to by inspectors had a good understanding of the local authority's pledge for looked after children, and most reported experiencing the effect of the pledge in their lives. This provides evidence that the pledge is a live document and children and young people in the care of Halton benefit from it.

92. Eighteen young people are involved in the CiCC, with approximately seven more involved in topic-specific sub-groups such as anti-bullying, Involve and website design. Work is underway, but not fully developed, to involve young people placed outside the local area, using technology such as Skype. The CiCC has developed a welcome pack which the participation officer delivers to newly accommodated children, including those placed out of area. This includes a range of information, such as how to complain and details of the local authority pledge and the CiCC. Eight young people have been trained to participate in

interviewing staff, and young people are also involved in the selection of providers through the commissioning process.

93. An awards ceremony was held in May which was attended by 70 children and young people; the CiCC is involved in planning next year's event, which is planned to have an Oscars theme. Recent arrangements have been made to involve young people in the corporate parenting partnership board but these are not yet fully embedded and effective.

The graded judgment for adoption performance is that it is good

94. Adoption is considered as a permanence option for all children by the second looked after review. A tracking system for children for who adoption may be the plan ensures that the child's journey is monitored from legal advice meetings onwards and delays are minimised. The adoption team manager or agency adviser oversees adoption plans and is a point of contact for all adoption work.

95. Halton's performance measured against the adoption scorecard is good, and improving. The data shows that the average time between a child entering care and moving in with an adoptive family was 538 days for the three-year average 2010 to 2013. This met the national threshold by 70 days and was better than both similar local authorities and the England average. The scorecard data for 2011 to 2014 shows continued improvement, with the threshold met and the average number of days now recorded as 521.

96. The average time between the local authority receiving court authority to place a child and deciding on a match to an adoptive family was 134 days for the three-year average 2010 to 2013. This met the national threshold and was again better than both similar local authorities and the England average. But the scorecard information for the three-year average 2011 to 2014 is 155 days, and does not meet the threshold by three days. Halton has a small number of children subject to adoption plans, and the matching and placement of a few children can affect the scorecard figures significantly. The recent dip in this scorecard figure is attributed to the delay in matching a sibling group where there was a complex medical history in the family background. These children are now successfully placed due to the determined efforts of the local authority in family finding.

97. The percentage of children looked after who have been adopted in the local authority was above the England average for the past five years until 2013–2014, when it dipped to 10%. At the same time the England level rose to 17%. Six adoption orders were granted last year; there have been twelve made to date this year, with a potential for a further seven to be made. This represents good progress.

98. Family finding is effective, and seven out of 10 children waiting for adoption at the time of the inspection had a match or potential match. The small

geographical size of the borough creates challenges in matching children with in-house adopters, but good collaborative working between Halton, Knowsley, Cheshire West and Chester in Together4adoption ensures that matches in a wider area can be considered. The local authority is also a member of Adoption 22, which is a consortium of 23 local authorities and voluntary adoption agencies in the North West of England. Adoption 22 maintains a database and search facility for children and adopters waiting for a match; children and adopters are referred to the database and to the National Adoption Register. Children are also featured in publications such as 'Be My Parent', and profiles are added to Adopt Northwest, which maintains a secure website for adopters.

99. The preparation and assessment of adopters is thorough, with the two stage assessment process well embedded. Adopters describe the preparation course as 'brilliant' and value the contributions from foster carers and adopters. Prospective adopter reports are of a good quality, with evidence of attachment style interviews, research and analysis. Inspectors saw evidence of, and spoke to adopters, who had broadened their offer during the assessment process, thus providing a wider choice of placements for siblings and children from different ethnicities.

100. A recruitment strategy is in place, with the local authority sharing many activities with other authorities through Together4adoption. The marketing plan covers a range of activities such as advertising, updates to websites and attendance at exchange days and community events. The recruitment target for 2013–2014 is the approval of 15 adoptive households. Between April and November 2014, there have been 42 adoption enquiries and 12 applications. Seven adoptive households are in assessment and there have been eight approvals this year. There are no Fostering to Adopt carers, but all prospective adopters are consulted about this during the assessment. Two voluntary agencies in the North West have been commissioned for this service and one has a Halton child placed under a concurrent arrangement.

101. The Adoption Panel is experienced, contains independent members with backgrounds in adoption, an educational psychologist, medical advisers and has access to legal advice. The panel provides robust examination of cases, with clear recording of reasons for recommendations. Panel minutes also reflect that the panel is fulfilling its quality assurance role and is checking timescales. Matching is thorough, with management oversight and scrutiny through the panel chair and agency decision maker. There is only one potential disruption recorded this year, which confirms that matching is effective.

102. The quality of child permanence reports is variable; some reports do not contain complete information regarding brothers or sisters or the health history of birth family members. The local authority is aware of this as an area in need of greater consistency.

103. The panel chair meets formally with the agency decision maker and panel adviser twice a year to discuss panel activity and practice issues. These meetings also inform the production of the six-monthly quality assurance

report. The panel chair completes the first section of the report, covering panel activity, quality assurance and membership, which is combined with statistical information from the panel adviser regarding children subject to an adoption plan. The meetings and quality assurance reports demonstrate good working relationships and opportunities for reflection on the work undertaken.

104. The adoption quality assurance report and panel minutes reflect the regular training that the panel receive. For example, case law updates have been provided and there has been recent training on safeguarding. Training has taken place with adoption team members, which is conducive to good shared learning and development of adoption practice.

105. Post-adoption support is currently provided to eight families, and 100 letter box exchanges are supported. Inspectors have seen letter box exchanges being reviewed and direct work done to assist families to draft letters. There has been one request for a post-adoption assessment for support during the year, which was appropriately declined. All adopters spoken to have been aware of post-adoption support and have received newsletters and information regarding post-approval training. The adoption team also offers support groups, family activity events, general advice and guidance. The local authority commissions a service from After Adoption Yorkshire to offer support and counselling to birth parents whose children have been adopted.

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

106. The children in care and care leavers team currently works with 62 care leavers. The personal advisers workforce is stable; they receive regular supervision and have manageable caseloads of approximately 20 young people. When young people reach the age of 17 years, a personal adviser works alongside their social worker. This ensures smooth transition arrangements and enables young people to establish a relationship with their personal adviser prior to case transfer at their 18th birthdays. Transition planning for care leavers with disabilities is also effective in Halton, and begins at an early stage. This ensures timely transfers to adult services and reduces uncertainty for young people.

107. Personal advisers are experienced and trained in direct work with young people, and support them in making decisions about their future aspirations. Personal advisers make active efforts to stay in contact with all care leavers, and to trace those with who contact is lost. In the majority of cases, young people are visited according to their individual needs or at a minimum frequency of eight-weekly. This ensures that personal advisers really know where young people are, that they are all right, and that their circumstances are not putting them at risk. At the time of the inspection the local authority was in touch with the vast majority (97%) of care leavers. One young person spoken to during the inspection stated, 'I am very happy and pleased with

Halton'. He reported that there was nothing the social worker or personal adviser could have done differently for him.

108. Care leavers benefit from a range of individualised packages of support which promote skills necessary for independent living. Life skills include practical skills (such as personal care, healthy eating, cooking, cleaning, shopping, budgeting), relationship skills and lifestyle skills (such as physical exercise, contraception, alcohol and drugs) to ensure successful transitions to independent living. Care leavers spoken to say that they have developed social skills required to live independently and make choices, but felt further support with budgeting would be of benefit to them.

109. There is a strong commitment from the local authority to provide a range of 'traineeships' for care leavers in Halton. The Halton People Plan 2012–2015 sets out the authority's approach and four of the local authority's 11 traineeships are currently held by care leavers. Traineeships result in employment opportunities and there has been recent success for two care leavers who are now employed by the local authority and one in the private sector.

110. The local authority reports that 97% of care leavers live in suitable accommodation. Most care leavers (six out of seven spoken to) told inspectors that they felt safe where they were living and were satisfied with their accommodation. Young people are benefiting from 'Staying Put' arrangements; four continue to live with their foster carers after the age of 18 years. Staying put arrangements are considered within the local authority's commissioning arrangements and this ensures that young people placed with independent fostering agencies have similar access to that of young people placed 'in house'. Eleven (17%) out of 62 young people are living in houses of multiple occupancy (HMO). The majority of these are purpose-built units, similar to halls of residence, are appropriate and meet the young person's needs, and are not considered as permanent housing options. At the time of the inspection no young people were placed in bed and breakfast accommodation.

111. A range of housing options are available to young people. These include social housing provided by Halton Housing Trust, private rentals and supported living accommodation. In partnership with Halton Housing Trust, the housing needs of care leavers are prioritised. All care leavers have access to 'Band A' social housing, the highest category of need. Tailor-made packages of support are commissioned to provide floating support, and two 'trainer flats' are available to ensure that care leavers are prepared and ready to take on their own tenancies. Care leavers spoken to by inspectors reported that their personal advisers work with them effectively to help find appropriate housing solutions that best meet their needs and preferences, but said they felt that the choice of housing is limited.

112. Care leavers spoken to as part of the inspection described strong and meaningful relationships with their personal advisers. The local authority celebrates the achievements of its young people, running an annual award ceremony that includes care leavers.

113. Care leavers with identified emotional or mental ill-health are well supported by tier two commissioned services that work solely with children in care and care leavers. Although young people spoken to were positive about the support to be healthy from their personal advisers, two of the seven expressed concern at the time it had taken to identify and support their mental health needs. The local authority is aware of this service need and is in the process of very significantly increasing investment in these services. Transition arrangements are in place and ensure that young people receiving a service from child and adolescent mental health services (CAMHS) are transferred to adult services in a planned manner.

114. Strong partnerships and good support from personal advisers and the education, employment and training (EET) worker has ensured a consistently higher proportion of care leavers move into education, employment or training than that found nationally; tracking shows that the current figure is 71%. Those in colleges are supported appropriately through bursaries, and child care is supported for young parents who want to continue their education. There has been a significant improvement in the number of care leavers entering university. Only one went to university in 2013, well below average, but six (9.7%) have started at university this year which is above the level for similar young people nationally.

115. The quality of pathway planning is too variable. Pathway plans require improvement. Seven (47%) out of a sample of 15 seen, do not demonstrate what difference the actions make to the young persons' skills and opportunities as they move into independence, employment or training. The local authority recognises this and recently commissioned and delivered pathway plan training to social workers and personal advisers. Personal advisers undertake regular reviews and update pathway plans. However, this does not afford young people an independent examination of their plans nor challenge to ensure that plans are making progress. In discussion, a small number (two) of young people were unaware that their pathway plans had even been reviewed.

116. A leaving care booklet 'Moving on in Halton' is available to young people, but is out of date and does not provide clear information about legal entitlements such as financial support, how to complain and rights to health histories. The local authority has adopted the DfE charter for care leavers, but the majority of care leavers spoken to were not aware of the charter or the 'Moving on in Halton' booklet, and were over-reliant on their personal advisers for information. In speaking with care leavers it was apparent that they had received financial support, but not all were clear about or could articulate their entitlement to services.

117. The majority (98%) of care leavers are registered with general practitioners but only 50% have a dentist. The looked after children's nurse prepares health information prior to the young person's 18th birthday. As the system is relatively new it is not yet fully embedded, and 42 care leavers (68%) do not yet have access to important information about their health histories. Care leavers spoken to by inspectors had limited knowledge of their entitlement to their

health information and some care leavers do not have health passports. This means they may be unaware of important details of their health history when seeking or requiring medical treatment.

118. The named teenage pregnancy midwife supports care leavers who are pregnant and works closely with personal advisers. For those care leavers (13) who are parents, support is offered through local children's centres and teenage parenting groups. Commissioned services such as 'teens to tots' are delivered in partnership with local secondary schools and nurseries over an 18-week period, twice a year. This enables young people to develop awareness and life skills to take responsibility for their lives and to make choices that are constructive and to their benefit.

Key judgement	Judgement grade
Leadership, management and governance	Requires improvement

Summary

Front line practice, management oversight and outcomes for children receiving early help and protection are not yet consistently good. Although the senior leadership team has taken action to improve services for children and young people by re-organising the way children's services are delivered these changes have not yet had sufficient impact for services to be uniformly good.

Based on an analysis of unmet need carried out in 2013, with a focus on children and young people suffering neglect, the local authority launched a new Levels of Need Framework with partners and the LSCB, and has undertaken a major service review and redesign. This followed the appointment of a new Operational Director for Children and Families Services in early 2013. At the time of the inspection, key elements of the new structure had only just been established (September 2014). This new structure for service delivery is not yet embedded, and further work is needed to ensure that the quality of practice in the new teams is consistently good.

The local authority's more robust approach to need and partner agencies' awareness of the Levels of Need Framework, have resulted in significantly increased numbers of children and young people becoming the subject of child protection plans and coming into care. The local authority has responded to this increase in identified need, and the subsequent additional pressure on services, but it has not been able to respond swiftly enough in some cases. A lack of management capacity has led to inconsistent management oversight and delay in progressing contacts for some children within the CART, and to high caseloads for IRMs and some social workers. This means that not all children and young people receive good services.

Systems to monitor performance are in place, and provide a good range of up-to-date performance data to front line and senior managers. Analysis of the quality of practice carried out through audits is used to help drive improvement, but is not routinely brought together with performance data to create a more rounded analysis of the effectiveness of services.

The local authority has a strong track record of delivering good services to some key groups of vulnerable children. It has been particularly proactive in developing awareness of, and services for, children at risk of CSE and has developed strong early intervention services based around effective use of the CAF.

Elected members and partners are all fully committed to the local authority's plans and are working together to deliver the change required.

The leadership in Halton has a clear view of development and improvement needs and continue to implement plans to strengthen services. Some of the changes to how services are structured and delivered are still relatively new and have not yet had sufficient impact to ensure that services are of a consistently good quality.

119. The Strategic Director, Children and Enterprise in Halton has the statutory responsibility for children's services in both Halton and in Cheshire West and Chester, a neighbouring local authority. Political leaders in Halton state that these arrangements are working well and that there have been benefits for the local authority. They are confident about the capacity of the Strategic Director to undertake his dual role effectively and they report that he has been influential in bringing back learning from Cheshire West to improve and strengthen services in Halton. The Strategic Director is supported in his dual role by a well-established and well-informed senior leadership team in Halton.

120. Effective governance arrangements are in place. The Children's Trust is co-chaired by Young People, with full stakeholder involvement through INVOLVE, the local authority's critical friend, an advisory group that is made up of young people, parents and carers. The Investing in Children and Young People's Board, chaired by the Chief Executive, the Health and Wellbeing Board and the Children's Corporate Parenting Board all provide additional oversight and challenge to the local authority. Through these boards young people are engaged in helping to shape services that meet their needs, and they know that the contribution they make is respected. They are passionate about their participation in key strategic activities and know that they bring added value to the governance arrangements of the local authority.

121. Arrangements to ensure that the chief officer and senior managers in the local authority are held to account for delivering services are good. The Children, Young People and Families Policy and Performance Board receives a wide range of reports on children's services to enable it to monitor and effectively challenge senior managers about the quality of services being provided. Although senior officers say that the discussions are challenging, the level of scrutiny is not always reflected in the minutes; this compromises the effectiveness and transparency of the process.

122. The Strategic Director, the Chief Executive and the chair of Halton Local Safeguarding Children Board (HSCB) meet regularly, providing an additional level of scrutiny and challenge to the performance of the local authority. These meetings have seen senior managers across the range of local authority services challenged to ensure that they contribute effectively to the safeguarding agenda. For example, the Chief Executive was proactive in ensuring that Public Health became a participating member of the local multi-agency child sexual exploitation (CSE) group.

123. Following the appointment of a new operational director for children and families services in early 2013, concerns emerged that the low numbers of child protection plans and looked after children were not proportionate to the level of need of children and young people in Halton. A review of services for children suffering neglect reinforced the view that service delivery needed to be more sharply targeted to achieve the best outcomes for children and young people. This has led to a major reorganisation of the way children's services are delivered in Halton. Although some changes were put in place in late 2013,

some are much more recent (September 2014), and improvements made in the quality of practice and outcomes for children are not yet fully embedded.

124. A single point of access to Early Intervention and Children's Social Care, the Children's Assessment and Referral Team (CART), was established in September 2013. Further changes were implemented in September 2014 to create separate Children in Need teams and a Children in Care and Care Leavers team. This has been a significant change of direction for the local authority. Progress to establish an organisational structure that focuses on the needs of children and reduces transition between services has been well managed and is increasingly effective. Social workers and partner agencies say that it is a step in the right direction for the service and for children. Apart from the CART, these changes are very recent and planned improvements, such as building greater capacity in the workforce, reducing caseloads, ensuring that children experience fewer changes of social workers and strengthening management oversight, have not yet been consistently achieved. This presents political leaders and senior managers in Halton with a significant number of challenges to ensure that the progress achieved so far leads to permanent and sustained improvement for children and young people.

125. Key strategic documents, such as the Children's Joint Strategic Needs Assessment and Halton Children and Young People's Plan, clearly identify local need and set out the local authority's priorities for children and young people. These are being used effectively to drive improvement. Through these well-defined priorities, the partnership is responding well to the prevalence of neglect, domestic violence and mental ill-health. Presenting needs at the point of referral shows domestic violence to be the most prevalent factor, and services have been commissioned to support children and young people. For example, 'Core Assets' provides support for non-violent partners with children living in the household.

126. Halton's Levels of Need Framework, which explains thresholds for services, is understood by partner agencies and applied well by social workers. Processes to step up work with children and their families from early intervention to statutory intervention, or step down when needs are reduced, are applied well.

127. The significant rise in children on a child protection plan where neglect (25% of plans) and domestic violence (24% of plans) are key factors, and a rising looked after children population, demonstrate that social work practice is now targeted more effectively and reaching the most vulnerable children. However, the Fostering Recruitment Strategy is not robust, and fails to set targets for recruitment of carers. Given the rising looked after population and the increase in the number of children requiring a placement, this restricts the choice of placements available for children without using agency foster caters and residential units.

128. Commissioning arrangements are focused on identified need and are well managed. Contract arrangements ensure a good join-up between commissioned and statutory services, for example by including an expectation

of use of the CAF within contract specifications. The local authority proactively manages commissioned services to ensure that they are providing good quality and good value services; providers describe the authority as a responsive commissioner. Additional investment has been targeted on key areas when necessary, for example, investment in community mental health services for looked after children and care leavers has seen a three-fold increase to ensure a more timely response for children and young people.

129. Partnership arrangements are strong and effective and further enhance the drive to improve services and outcomes for children and young people. For example, good systems and arrangements are in place to track and check the safety and achievements of home educated children and children missing education. Partnership working with local authority-wide services and the private sector has led to a higher than average proportion of care leavers moving into education, employment and training than that found nationally.

130. Halton's multi-agency child sexual exploitation (CSE) operational group is a sub-group of the local safeguarding board. It meets to share information on children missing from care, home and education to ensure a greater triangulation of information across the partnership. The implementation of pan-Cheshire CSE policies and procedures provide a consistent approach to the issue across the partnership and across neighbouring local authorities. Children at risk and potential risk of exploitation are known and tracked. Whilst the local authority knows it has some children at risk, it is confident that the early identification of risk reduces the danger of organised activity. Police operations have taken place to disrupt activities and, although no criminal charges have yet been brought, harbouring notices have been effectively issued. A pan-Cheshire publicity campaign was launched in January 2014 to raise awareness amongst children and young people, their families and carers. Catch 22, a commissioned service in Halton, has been used to raise awareness of the issue amongst local businesses and the night time economy. The learning outcomes from recent national child sexual exploitation serious case reviews have been used well to support learning across the partnership.

131. Performance management and audits inform service delivery and support managers in focusing their energy on delivering the right services to the right children. Managers at all levels of the service receive performance data and a short narrative to help identify where practice is falling short and enable them to performance manage more effectively. However, quantitative performance data and the information about quality from audits and other sources, such as complaints and feedback from young people, are not routinely brought together to create a more holistic analysis of practice that could better support improvement.

132. The safeguarding unit is responsible for undertaking case file audits and having oversight of compliance. Overview reports to senior managers identify themes emerging from the audit programme. Weaknesses in case work activity are shared with line managers and taken forward into supervision to support individual learning. Recent audits show that, overall, there are good examples

of effective inter-agency working. Areas for development identified have included the timeliness of assessments and the inclusion of the voice of the child in case records.

133. The workforce strategy is focused on building capacity in front line services and within the leadership and management team to ensure that the workforce is skilled and able to deliver services that have a positive impact on children and young people. The Divisional Manager for Children in Need Services leads on the strategy and is well placed to understand the demands on the frontline service, shortfalls in capacity and where performance issues are affecting service delivery. Increasing the capacity in the workforce has seen an over-reliance on the use of agency staff, with 16 posts being filled by agency workers at the time of the inspection. The local authority is working hard to reduce its dependency on agency staff, and some agency staff told inspectors that they are considering contracts with the authority. Rising numbers of looked after children and children subject to child protection plans have meant that there is currently insufficient capacity in the child protection conference chair and IRM service.

134. The local authority continues to invest in its workforce. It has established a career structure and provides regular reflective supervision and learning opportunities to enable social work to flourish. The Assessed and Supported Year in Employment (ASYE) is valued and supervision records show that newly qualified social workers benefit from protected caseloads, increased levels of supervision and joint working with more experienced colleagues. Social workers are skilled and experienced and are able to talk about the impact their practice has on improving outcomes for children. They are enthusiastic and positive about working in Halton, and report feeling supported by managers who are visible and accessible. Managers deal with poor performance effectively, including when they consider that the work of agency staff falls short of the authority's expected standards of practice.

135. The training plan links to the workforce strategy, and shows that an effective range of opportunities are in place to develop social workers' skills and knowledge, including performance review days, 'big conversation' days, and development days. A significant level of training to support social workers to understand the impact of neglect on outcomes for children and young people has been well received. Social workers are well aware of learning from recent high profile serious case reviews, the Munroe review into social work practice and outcomes from thematic reviews. They use their learning to inform their own practice. For example, the domestic abuse risk matrix is used well to identify threats to children's safety.

The Local Safeguarding Children Board (LSCB)

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

Summary of findings

The LSCB requires improvement because:

Partnership working

- Tracking the outcomes of actions set at Board meetings is not robust. There has been significant delay in the findings from one task and finish group being reported back to the main Board.
- The annual report for 2013–14 has not been published. The delay in publication limits its impact on informing and shaping practice across the partnership, and means it is not accessible to the general public, children and young people, parents and carers. It prevents them from understanding how safe children are in Halton and how effective the Board is in carrying out its statutory duties.
- Attendance by some partner agencies at the main Board meetings has been inconsistent.
- Internal processes in some partner agencies have caused delay and limited the timeliness of information sharing with the Board.

Awareness raising and learning

- Work with local faith-based organisations is under developed. Raising awareness across the partnership to promote private fostering arrangements through the multi-agency group established by the Safeguarding Board has stalled.
- Attendance at multi-agency training days by some agencies is poor.

Participation

- The Board's engagement with children and young people is at an early stage of development.

What does the LSCB need to improve?

Priority and immediate action

136. Ensure that the Board's annual safeguarding report is published immediately.

137. Ensure that all partner agencies attend Board meetings regularly and are active participants in the work of the Halton Safeguarding Children Board.

Areas for improvement

Partnership Working

138. Work with pan-Cheshire partner LSCBs to ensure that a chairperson for the Pan-Cheshire Child Death Overview Panel is appointed as soon as possible to ensure that the panel's work does not lose momentum.

139. Establish effective information sharing arrangements with health partners to ensure that their own internal processes do not create delays in the work of the Board.

140. Ensure that actions identified at Board meetings are followed through systematically to hold all partners to account for the work they do on behalf of the Board.

Awareness raising and learning

141. Establish an effective working partnership with local faith-based organisations, utilising the role of the appropriate Board members to engage with the wider community.

142. Ensure that relevant staff from all partner agencies attend regular multi-agency training events to maximise opportunities for learning to support professional development.

143. Ensure that all partner agencies have a good understanding of private fostering arrangements and that effective processes are in place to promote the notification and understanding of private fostering arrangements across the partnership.

Participation

144. Put in place opportunities for children and young people to inform the work of the Board.

Inspection judgement about the LSCB

145. Halton Safeguarding Children Board (HSCB) is independently chaired. The Chair has been in post for just under 12 months. As a former senior local police officer with extensive safeguarding experience, he is well placed to satisfy himself and the Board that all agencies are fulfilling their statutory duties to safeguard children. He provides effective oversight of the Board's business. The chair came into post at the point that the HSCB was implementing a new streamlined membership of the main Board and was able to oversee the initial stages of implementation. Membership is now is at a sufficiently senior and strategic level to enable change and promote the safeguarding agenda across the partnership. Board members speak positively about the impact the new chair has had. The Board's development has been supported by a thematic day

on the 'Way we Work' which helped to reaffirm the Board's role and business agenda.

146. As part of the overall review of the safeguarding board and to avoid duplication of work across the region, a pan-Cheshire Policy and Procedures sub-group was established in January2014. This followed the establishment of a pan-Cheshire Child Death Overview Panel (CDOP) in April 2013 and a Pan-Cheshire Strategic CSE, Missing & Trafficked Children Sub Group in September 2012. Each sub-group reports to all four LSCBs in Cheshire, with the pan-Cheshire CDOP annual report reflecting the business of the region. These groups are good examples of the effective multi-agency arrangements in place across the Cheshire region.

147. New sub-groups have been developed to reflect the Board's priorities for 2014–15. The Health sub-group provides oversight of safeguarding priorities in relation to health and although in its early stages of development, has established a number of work streams to enable a greater focus on health issues. For example, improving attendance at multi-agency safeguarding training for doctors, ensuring each of the 17 GP practices in Halton has a designated safeguarding lead to support better attendance at child protection conferences. The board and the health sub group have effective oversight of performance data. This has been used to challenge health and social care partners on the conducting of health assessments for children in care which resulted in swift action and significant improvements in performance and services children and young people.

148. Effective joint protocols between Halton Children's Trust, the HSCB and Halton's Health and Wellbeing Board are in place. How these bodies interact and work alongside each other whilst retaining their independence is clearly outlined in the protocol. The procedure supports clear governance arrangements across the borough.

149. The appointment of the new chair, changes made to the membership of the Board, the development of the new sub-groups to reflect the Board's business and the development of pan-Cheshire sub-groups have been swift. However, these developments need to be embedded and progress maintained to achieve the increased effectiveness that the HSCB aspires to.

150. The 2013–14 annual safeguarding report is still in draft. There are clear priorities and actions set in the business plan that have been drawn from the draft annual report, and a clearer identification of the most vulnerable groups in Halton to help focus the work of the Board. However, difficulties in bringing key strategic partners together to jointly consider the supporting narrative for the annual report have contributed to the delay in publication. This prevents the report from fully informing and shaping practice across the partnership. It also means it is not accessible to the general public, children and young people, parents and carers, and prevents them from understanding how safe children are in Halton and how effective the Board is in carrying out its statutory duties.

151. Insufficient workforce capacity to undertake the work required by the Board within the safeguarding board core team has contributed to some delays in the Board's business. Tracking the outcome of actions agreed at Board meetings is not robust. There has been significant delay in the findings from the task and finish group on Managing Risky Adolescence being reported back to the main Board. This was first raised in January 2014; meetings have been cancelled and, to date, their findings have not been presented to Board.

152. The effective oversight by the Board of the local authority's private fostering arrangements has not progressed as well as it should have. A multi-agency group established to raise awareness and promote the notification of private fostering arrangements in the borough has stalled. This work needs to be refreshed and strengthened to ensure that it progresses and is joined up with other work areas such as CSE and missing children.

153. Work with local faith-based organisations is under developed. This work needs to be more focused to ensure that the needs of the wider community are considered in the Board's business.

154. A good range of reports are presented to the main Safeguarding Board, which enables the Chair to provide effective challenge across the partnership. In his meetings with the Chief Executive and the Director of Children's Services the HSCB Chair has raised concerns regarding the churn in social work resources and recruitment of additional staff. Reports show that the Board has been monitoring the effectiveness of early help and, in particular, the local authority's heavy reliance on agency staff in one team. The Board undertook additional scrutiny by auditing a random selection of 30 cases across the two children in need teams. Through this work the Board was able to satisfy itself that no children were identified as being at immediate risk.

155. The Board has streamlined the Section 11 auditing process, developing an on-line electronic template to support the work of those agencies that sit on all four local safeguarding boards across the Cheshire region and are required to provide an audit to each board. The template is completed on-line and submitted to the respective business managers of each board, thus avoiding duplication of work. Cheshire Police said that the new template has saved time and was an effective example of the four local boards working well together.

156. Some schools have struggled to complete their own Section 175 auditing responsibilities. Returns were as low as 60%. This low return was reported to the Board's Executive, following which the HSCB chair wrote to all schools outlining the expectation to complete the audits. Following discussion between the Chair and Strategic Director, the Strategic Director also challenged schools at a meeting with Head Teachers. This improved the return significantly. The Local Authority's Link Officers then followed up with the remaining schools. The Safeguarding Children in Education Officer provides support to all schools in the Section 175/157 process. This action led to an increase in returns to 93%. Outcomes from the Section 11 and Section 175 audits are being collated and are planned to be reported on at the main Board in January 2015.

157. The outcomes from multi-agency audit days are used effectively to drive improvement. Lead officers from a range of agencies are involved in auditing case work. An overview report by the Scrutiny and Performance sub-group is detailed, and highlights learning from the audits. It also provides evidence and advises the Chair to challenge agencies where aspects of practice are not good enough. Themes emerging from 2013–14 audit days show that in cases where children were subject to a CAF, multi-agency working is strength, with good challenge across agencies. The HSCB challenged the local authority to improve practice after drift was identified in the early stages of care planning arrangements in some cases where there had been a significant number of changes of social worker.

158. Recognising that the prevalence of child neglect made this the main reason for many referrals to social care, the Halton Children's Trust in partnership with the HSCB developed the Neglect Strategy. The Board is responsible for its implementation and for monitoring the impact of the strategy. The delivery plan is well structured. Significant levels of training are supporting professionals in identifying and responding to child neglect. As a consequence, through effective practice, the number of children safeguarded through a child protection plan where neglect is the key factor rose from 33% in 2012-13 to 54% in 2013-14. The LSCB has successfully initiated an innovative piece of practice to support schools in helping children when domestic abuse is a concern. Operation Encompass is led by the police and education. Schools are notified by the police when incidents of domestic abuse have occurred when children may have been present. This enables school staff to provide an immediate response to support vulnerable children at risk.

159. The multi-agency CSE operational group shares information on children missing from care, home and education and provides a forum for the triangulation of information across the partnership. The implementation of pan-Cheshire CSE policies and procedures provides a consistent approach across the partnership and neighbouring authorities. Children at risk of exploitation are known and tracked locally and regionally. A pan-Cheshire publicity campaign launched in January 2014 has helped to raise awareness amongst children and young people, their families and carers. The learning outcomes from recent national child sexual exploitation serious case reviews have been used to support learning across the partnership.

160. The Learning and Improvement Framework is driving sustained improvement in social work practice. The need for continuous learning is recognised and this is achieved through a range of activities including multi-agency audits, single agency audits and Section 11 audits. A quarterly newsletter on the HSCB website is used to share good practice across the partnership and is accessible for all practitioners. Board members have access to a secure 'members' area' section of the HSCB's website. All other sections of the website are open to all, so the public as well as practitioners can access the professionals section of the LSCB website where they can find safeguarding policies and procedures and learning from practice.

161. There has been low take-up of multi-agency training by some partners, namely, the Cheshire Fire and Rescue, Community Rehabilitation Company and the National Probation Service. The learning and development officer is meeting with the service heads to discuss attendance and encourage participation in the multi-agency learning opportunities available. The Board has reviewed its on-line training needs analysis process for all professionals across the partnership and launched a new model in early November. This seeks to better inform the development and delivery of training provision to meet the demands of the workforce. E-Learning courses have been increased to add variety to learning styles.

162. There have been no serious case reviews held in Halton in the last 12 months. The Critical Incident Panel (CIP) has appropriately commissioned an independent review to identify learning in one particular situation and has secured the services of an appropriately qualified and experienced individual to undertake this work. All deaths and life threatening events are appropriately referred to the safeguarding business manager, HSCB Chair and the Chair of CIP. The panel was established in January 2014 and a new chair appointed. She is keen to maximise the impact of the panel by broadening the panel's brief to include lessons to learn from a number of complex cases that do not reach the threshold for a serious case review (SCR). She is working across the partnership to support learning, including reviewing instances of good practice in complex case work. Learning from national SCRs is used to improve practice; for example, the panel sent letters to local GPs highlighting the recommendations in a recent national SCR regarding the risk of de-registering families who are hard to engage with.

163. A pan-Cheshire Child Death Overview Panel (CDOP) established in April 2013 is currently operating without a chair. The four regional chairs of each LSCB are working closely to appoint a new chair to the panel to ensure that the work proceeds. The CDOP report to HSCB focused on local concerns, including five child death notifications, which is significantly lower than the national average. Emerging themes are used to inform public health campaigns, such as an imminent 'safer sleeping' campaign with Merseyside CDOP, and to provide challenge to agencies, for example inconsistent health engagement in the 'rapid response' provision. Working across regional boarders, panel chairs have highlighted the absence of a national system to collate information from all CDOPs. Cheshire and Merseyside CDOP chairs have written to NHS England recommending a national programme of awareness raising.

164. The Board has started to consult with children and young people through a local event on how best they can engage them in the work of the Board and is also looking at how other LSCB's engage children and young people. This is aimed at enabling children and young people to be effective participants in borough-wide business. Young people have helped to design the HSCB E-safety leaflet.

What the inspection judgements mean

The local authority

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

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

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

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

The LSCB

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

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

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

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

Information about this inspection

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

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

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

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

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

The inspection team consisted of seven of Her Majesty's Inspectors (HMI) from Ofsted.

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