

Wakefield Metropolitan District Council

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

and

Review of the effectiveness of the Local Safeguarding Children Board¹

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Children’s services in Wakefield Metropolitan District Council require improvement to be good.	
1. Children who need help and protection	Requires improvement
2. Children looked after and achieving permanence	Requires improvement
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 Inspections Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

Executive summary

Wakefield District Council has made some progress since the last inspection in 2012. The appointment of the current director of children's services (DCS) in 2013, led the way for significant cultural change in children's services and, following a restructuring of the senior management team and implementation of a refreshed vision and strategy, services to children and families are now improving. More recently, improvement has accelerated, following the introduction of a nationally recognised model of social work practice. Positive changes can be seen in how families are better engaged and how children are listened to and have their views taken account of. However, a shortfall in the local authority's capacity to use data to produce a suite of accurate performance reports means that managers spend too much time developing bespoke performance management systems, which are too reliant on memory to be effective. The lack of a general overview of performance over time and against comparators is hampering senior leaders' ability to drive forward further improvement. This is compounded by the electronic recording system, which makes recording and extracting information problematic. Difficulties using the electronic recording system were an issue identified in previous inspections, and there is still no clear plan in place to resolve this.

The DCS and senior management team have worked hard to implement a number of key strategic priorities successfully, and these are now starting to have a positive impact on improved outcomes for children. For example, this positive leadership means that children who go missing or who are at risk from being sexually exploited are identified and responded to swiftly. Another key area of improvement has been the development of effective multi-agency early help services.

Strong political involvement means that there are clear lines of accountability and scrutiny. The DCS and senior management team recognise that some key issues have not been addressed quickly enough, such as ensuring that clear and deliberate decision-making underpins social work practice, and that consistent management oversight leads to good and timely social work. While these weaknesses are being systematically addressed, and inspectors saw no children at risk of immediate harm, they remain areas for improvement.

While there is strong strategic vision, this is not yet fully implemented operationally, and the consistency of practice is not yet assured. Social workers' caseloads are too high in some teams, and this has an impact on their capacity to provide a consistently good-quality service. Frontline managers' ability to challenge is hindered in some teams by the lack of reliable performance information and the workload created by the number of social workers that they have oversight of.

Arrangements for the management of contacts and referrals are generally of good quality, and cases are assessed and responded to swiftly. However, a consultation line to advise agencies on action to be taken at an early stage is not monitored effectively, and some cases seen should have been referred to children's social care for further checks and information gathering. A high proportion of child protection enquiries do not lead to an initial child protection conference (ICPC), although all

child protection enquiries sampled during the inspection met the threshold for an investigation. The local authority has not fully explored the reasons for this and therefore does not know what action may be needed to address this.

Most assessments are completed within the target set as standard by the local authority but are not yet being completed within the timescales of the child.

The use of safety plans as tools to help social workers to identify risk factors and intervention is not yet fully embedded. In a small number of cases, safety plans are being implemented alongside children in need or child protection plans, and this does not provide a consistent message about what needs to change.

When young people present as homeless, too many of them are placed in bed and breakfast accommodation. While this provision is not used for care leavers or for young people considered vulnerable, this is not conducive to ensuring a safe environment for young people who are homeless.

Children looked after are generally well supported, particularly in relation to the educational opportunities afforded to them, and academic results are good. They are encouraged to contribute to their care plans, and advocates are widely used to support this. However, assessments and plans for children looked after are not regularly updated to reflect their progress.

Professionals involved in reviewing plans for children looked after do not always provide sufficient challenge to ensure that progress is made and tasks are completed in a timely way. Although the views of children are sought and recorded in many cases, and this has increased, particularly in the past six months since the introduction of the new social work model, not all children contribute to or are involved in decisions and plans made for them.

There are not a sufficient number of carers to meet children's needs in the local area. This has recently resulted in a decline in placement stability for children. The sufficiency strategy is being refreshed to address this, as the current plan does not meet local needs or take account of future demand. Challenges in relation to ensuring accurate performance information are detracting from the local authority's ability to identify service needs and areas for further improvement.

Good practice in the adoption service means that children are placed for adoption with their brothers and sisters in the vast majority of cases, and children considered difficult to match are adopted.

When life story work is completed, it is of good quality but, in many cases, it is not started early enough or finished in a timely way.

Care leavers are supported to make the transition to living independently by workers who go the extra mile to keep in touch with them. However, the range of suitable housing solutions for care leavers is limited, and they are not prioritised for housing by local providers.

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The local authority

Information about this local authority area²

Previous Ofsted inspections

- The local authority operates five children's homes. All were judged to be good or outstanding in their most recent Ofsted inspection.
- The previous inspection of the local authority's arrangements for the protection of children was in October 2012. The local authority was judged to be adequate.

The previous inspection of the local authority's services for children looked after was in December 2010. The local authority was judged to be good.

Local leadership

- The DCS has been in post since July 2013.
- The chair of the LSCB has been in post since January 2010.
- The local authority has commissioned out six services.

Children living in this area

- Approximately 69,136 children and young people under the age of 18 years live in Wakefield. This is 20.9% of the total population in the area.
- Approximately 20.6% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
 - in primary schools is 15.2% (the national average is 15.6%)
 - in secondary schools is 13.5% (the national average is 13.9%).
- Children and young people from minority ethnic groups account for 7.4% of all children living in the area, compared with 21.5% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Asian or Asian British and Mixed.
- The proportion of children and young people with English as an additional language:
 - in primary schools is 9.1% (the national average is 19.4%)
 - in secondary schools is 5.5% (the national average is 15.0%).

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

Child protection in this area

- At 31 March 2016, 2,108 children (DfE definition) had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 2,588 at 31 March 2015.
- At 31 March 2016, 193 children and young people were the subject of a child protection plan. This is a reduction from 287 at 31 March 2015.
- At 31 March 2016, nine children lived in a privately arranged fostering placement. This is an increase from seven at 31 March 2015.
- Since the last inspection, five serious incident notifications have been submitted to Ofsted and two serious case reviews (SCRs) have been completed at the time of the inspection.

Children looked after in this area

- At 31 March 2016, 480 children were being looked after by the local authority (a rate of 71 per 10,000 children). This is a reduction from 495 (72 per 10,000 children) at 31 March 2015. Of this number:
 - 147 (or 30%) live outside the local authority area
 - 58 live in residential children's homes, of whom 52% (27) live outside the local authority area
 - 2 live in residential special schools, of whom 100% live outside the local authority area
 - 313 live with foster families, of whom 29.4% live outside the local authority area
 - 55 live with parents, of whom 5% live outside the local authority area
 - 22 are unaccompanied asylum-seeking children (UASC).
- In the last 12 months:
 - there have been 51 adoptions
 - 24 children became subject of special guardianship orders
 - 195 children ceased to be looked after, of whom 1% subsequently returned to be looked after
 - 21 children and young people ceased to be looked after and moved on to independent living
 - 4 children and young people ceased to be looked after and are now living in houses in multiple occupation.

Recommendations

1. Accelerate plans to improve the full utilisation of the electronic recording system, so that accurate data informs performance management reports to enable senior leaders to measure and improve practice and to support frontline managers and staff in their oversight and management of work.
2. Carry out a review of cases that meet the threshold for section 47 investigations, but do not progress to ICPC, to understand the reasons for this better, and to ensure that the social work response is proportionate.
3. Ensure that the placement needs of children looked after are fully explored and well understood, in order to inform the sufficiency strategy more effectively and to improve placement stability.
4. Ensure that the use of bed and breakfast accommodation for young people who are homeless ceases. When bed and breakfast is used in the interim, ensure that robust risk assessment and risk management plans are in place for each young person, with a view to moving them on swiftly to suitable accommodation.
5. Continue to reduce the caseloads of social workers to facilitate effective social work practice and to ensure that all frontline managers have manageable workloads in relation to the number of social workers that they manage.
6. Ensure that the consultation service for professionals provides both consistent advice and timely completion of agreed actions, with information being entered appropriately onto the case management system.
7. Ensure that assessment timescales are set and completed in relation to the needs of the child, that assessments consistently identify wider and emerging risks and that they underpin outcome-focused planning effectively.
8. Ensure that planned interventions and letters before proceedings are outcome focused, with clear measures for what needs to be achieved by whom and within what timescale, and that contingency plans are clearly articulated.
9. Further embed the use of child safety plans as social work tools to inform risk and intervention in cases and ensure that these are consistent with child protection or child in need plans.

10. Ensure that independent reviewing officers (IROs) have sufficient capacity to have an impact upon the quality of frontline practice and planning.
11. Ensure that the views of all children are sought routinely and that needs arising from diversity are identified and addressed.
12. Ensure the timely completion of life story work.
13. Ensure that senior managers establish closer and more effective working relationships with local housing providers, to increase care leavers' access to tenancies.

Summary for children and young people

- Senior managers and social workers ensure that when children need protecting quickly they do this straight away. However, there are sometimes delays in providing the support that children and families need because social workers responsible for doing this have too many cases to deal with. Managers have started to respond to this by increasing the number of staff, but have not yet fully solved the problem.
- When assessing and planning the support and services that children need, social workers are not always good at taking into account children's views or information about their identities and family backgrounds. They do not always keep the records of their work with children fully updated.
- Managers have improved the way that professionals work together to help families, and this is supporting children and families to remain together when it is safe to do so.
- When children become looked after, some of them have to move too many times before they find a permanent home. Managers know that they need to get better at providing the right places for children to live and are trying hard to improve this.
- Social workers and foster carers are good at making sure that children are healthy and develop well. However, some children and young people wait too long to receive support for emotional well-being.
- The very experienced adoption team is successful in finding good families for children to live with permanently, and it makes sure that children are placed with adoptive families as soon as possible.
- The council provides plenty of support to help children to do well at school. Over time, the children and young people whom they look after have improved their results.
- When young people leave care, they receive good support from their personal advisers and social workers. They are prepared well to live independently in a safe place and are helped to continue with their education, to receive further training or to seek employment.

The experiences and progress of children who need help and protection	Requires improvement
<p>Summary</p> <p>During the course of this inspection, no children have been found in situations of unacceptable risk or in situations of unassessed or unmanaged risk of significant harm. Improving practice was identified, but some of the good practice seen is not yet sufficiently embedded or widespread for the judgement to be good.</p> <p>Variability in the timeliness and quality of social work practice includes the core areas of assessment, planning and reviewing. Immediate risk is promptly identified and responded to at the service’s front door, with the response of the out-of-hours service being particularly strong.</p> <p>Wider and emerging risks are not regularly identified or managed in a timely way. Challenge and decision-making at child protection conferences have not consistently ensured that a reduction in risk has been sustained prior to children being stepped down from a child protection plan. Some timely and effective practice has been seen, but this is not yet sufficiently widespread.</p> <p>Enquiries under section 47 of the Children Act 1989 are thorough and timely, and cases seen on inspection met the threshold for intervention, but the relatively high number of enquiries and the high percentage of these that do not go to child protection conferences mean that threshold applications should be kept under review. The local authority does not fully understand the reasons for this.</p> <p>A consultation service provided for professionals as part of the front-door services is valued by external partners. However, a lack of management oversight has not ensured consistently appropriate responses in all cases. Senior managers responded to this finding during the inspection, instigating a review of the service to ensure that the advice being given to other agencies was scrutinised promptly by managers.</p> <p>Variability in the frequency and effectiveness of management oversight has led to increased caseloads and stretched capacity in the assessment service, contributing to variability and drift in practice. Senior management responded to this finding by increasing the capacity of the service.</p> <p>The views and experiences of children are not yet consistently evident, and children’s diverse needs are not always identified effectively, fully explored or addressed in assessments of their needs.</p> <p>Strategic focus on early help and the establishment of the early-help hubs provide a strong foundation for delivery of the early-help offer. Practice in relation to stepping work up to and down from social care has significantly improved, although some developments are still very recent.</p>	

Inspection findings

14. A strong and effective basis for delivering the early-help offer is provided by a clear strategic focus on early help and the implementation of the early-help hubs. Good-quality casework was seen by inspectors, with children's views included effectively. There is effective monitoring of early help by the Wakefield District Safeguarding Children Board and a timely response to recommendations to improve practice, for example, through multi-agency audits. Timely and thorough allocation processes and effective case management ensure that, when risks to children increase, their cases are escalated appropriately for a social work response. This recently improved practice is supported by the completion of single assessments by the early-help principal social workers based in the early-help hubs. This is promoting a clearer identification of services to support families at an early stage and ensuring a more consistent response if needs or risks escalate.
15. Domestic abuse and preventing violent extremism are prioritised at an early stage, with needs identified well and preventative work being undertaken effectively. The Do it Differently girls group, run for teenage girls with a history of violence towards others including their parents and other young people, is well planned and run effectively by multi-agency staff and is an example of best practice. However, the limited performance information means that it is difficult to monitor, quality assure and assess the impact of early-help work and to ensure consistency between the hubs.
16. A telephone consultation system for agencies to seek advice from social workers was set up in March 2016 and is viewed positively by professionals who feel more supported. However, management oversight of this service is not ensuring an appropriate check and balance in relation to decision-making. Of 117 consultations up to the time of the inspection, only 17 have become contacts (15%) and, in a sample of these cases, half should have had some social work response, either by way of recording as a contact or by undertaking further checks to inform decision-making about whether cases meet the threshold for social work intervention. During the inspection, senior managers took immediate action to review these cases and strengthen management oversight of the service. (Recommendation)
17. When cases meet the threshold for referral to children's social care, there is an effective, multi-agency response supported by the work of the triage service, the Multi-Agency Safeguarding Hub (MASH) and the joint investigation team (JIT). Immediate risk is identified effectively and responded to. Thorough, timely information gathering and analysis, with clear management direction and oversight in the vast majority of cases,

ensure that children at risk of immediate harm are protected. Parental consent is appropriately secured.

18. The front-door service is not supported by accurate and timely performance information or system alerts. Managers have developed their own paper-based systems to support tracking and oversight of work, but this is time consuming and not as reliable as comprehensive system-based alerts and reports. There is an absence of accurate performance information to provide a detailed understanding of trends and outcomes. For example, the absence of detailed information on the outcomes of contacts and referrals means that an overview of current practice is not assured. (Recommendation)
19. The percentage of re-referrals (44%) is higher than that of comparator authorities (22%). Cases sampled demonstrate recently improved and appropriate decision-making in the last six months, since the introduction of a recognised social work model and movement of managers between teams. However, historically decision-making has been inconsistent, resulting in some cases being closed too soon.
20. Enquiries undertaken by the JIT, under section 47 of the Children Act 1989, are timely, suitably initiated following multi-agency strategy discussions and result in clear decision-making to secure children's protection through safety plans. Enquires are thorough and conducted by competent and experienced social workers who are well supported. In a small number of cases seen, the planning of the enquiry between the police and social care is not coordinated effectively, which means that work with children is not done with a shared approach.
21. A very high percentage (79%) of child protection enquiries undertaken across all teams do not proceed to ICPC. The rate of enquiries initiated is significantly above comparators and, at 283.2, is higher than 153.9 in 2014–15. In the vast majority of cases sampled, the criteria for an enquiry were met and, following an appropriate assessment, there was a clear rationale for not progressing to ICPC. However, this is an issue that the local authority and its partners have not fully investigated and reviewed to ensure that families are not subject to unnecessary intrusion and that interventions are proportionate. (Recommendation)
22. High-quality responses to children's needs out of hours by the emergency duty team ensure that children's immediate safety is secured and that arising needs are continually assessed. This is a particular service strength. Experienced social workers provide a wide-ranging service to both new and open cases, including welfare visits, follow-up on cases that have come through the duty team and timely completion of child protection enquiries, including strategy discussions. Co-location with the police facilitates effective multi-agency information-sharing and

decision-making and a timely response to children and families out of hours.

23. There is effective signposting to the early-help hubs for family support when cases do not require a social work intervention and when children and families no longer need support from children's social care. There is recently improved coordination of cases stepping down from locality teams to the early-help hubs, with clear planning and appropriate involvement of families. There are improved line management arrangements of the early-help principal social workers, timely constructive case discussions and early alerts about work being considered for transfer.
24. When children are not at risk of immediate harm, cases are transferred to the locality teams for an assessment of needs to be undertaken. The quality of assessments is variable, and not all children have their needs comprehensively identified or supported in a timely way. Historical practice with children who have been subject to plans for neglect shows missed opportunities to identify risk and to intervene earlier. While the most obvious risks are identified in the majority of cases, other risks are not addressed, for example the impact of enduring poor parental mental health. In more recent assessments, which use safety plans and a recognised model of assessment, neglect is better recognised and responded to. The local authority has been slow to implement the LSCB's strategy for neglect and to provide multi-agency training on neglect, which has meant further delay in improving responses to children who are neglected.
25. While good practice was seen in some cases, there are delays in the allocation, progression and completion of some assessments. Assessment timescales are not consistently set in relation to the needs of the child, and a target of 45 days is routinely used. The authority's current performance in relation to assessment completion within 45 days is 76%, which is below the latest published data for comparator authorities at 84%. The local authority has recognised this and recently changed practice to ensure that timescales are appropriate and are regularly reviewed. No routine performance reports are available on this measure, and it was therefore difficult for inspectors to assess progress on this measure during the inspection. (Recommendation)
26. Assessments undertaken in the past six months use a nationally recognised model of social work practice to give a clear picture of strengths, vulnerabilities and risks for the child and family, taking into account historical factors, and giving a clear view of the child's lived experience. These assessments underpin subsequent planning effectively. However, these are recent improvements and assessments prior to this time have not consistently identified wider and emerging risks. Even when the information gathered is thorough, assessments are

not always translated into clear outcome-based plans, with the proposed plan listing a series of tasks to be completed rather than needs to be addressed and outcomes to be achieved.

27. Effective systems are in place to assess and monitor arrangements when children are placed with relatives or friends by the local authority, under regulation 24 arrangements. There is evidence of appropriately thorough assessments being completed and of challenge about approval of placements. However, workers do not always recognise when children are living in circumstances to which regulation 24 arrangements apply, and some cases were seen which should have had an assessment subject to regulation 24.
28. Caseloads of social workers in the assessment service are high, with some carrying over 30 cases. The number of social workers managed by the assessment team managers is also high, with one of the managers supervising 11 staff. This compromises the ability of staff and managers to undertake and drive timely and comprehensive social work. Senior managers are aware of this shortfall and have put in place measures to manage pressures in the assessment service by setting up a third assessment team and increasing the social work and management capacity across this service area, but action taken has not yet had sufficient impact. (Recommendation)
29. Concurrent use of safety plans, child protection and child in need plans means that in some cases more than one plan is being used, which causes confusion for families. The majority of child protection and child in need plans do not clearly define outcomes, measures, responsibilities or timescales, but rather describe actions to be taken. This means that families are not sufficiently clear about what they need to do to ensure that children's needs are met and that they are safe and to ascertain how progress will be measured. This is also the case in pre-proceedings letters to parents, which do not consistently make clear to parents what is required of them and the action that will be taken if circumstances do not improve. (Recommendation)
30. Effective planning was seen during assessments in which single safety plans are used, which are later developed into child protection or child in need plans. This ensures clarity, from an early stage, about what needs to happen. Recent changes to the format of child protection plans have supported more comprehensive, outcome-focused planning with clearly articulated contingencies.
31. Timeliness for ICPCs, taking place within 15 days of the start of a child protection enquiry, is reported by the local authority to be at 97%, which is well above the most recent published data (DfE for 2014–15) showing comparator authorities performing at 82%. The proportion of children who have been subject to a second or subsequent child protection plan

is reported to be 25%, which is higher than comparators at 16%. Inspectors are not confident that this data is accurate. A legacy of ineffective challenge, poor decision-making in child protection conferences and an insufficient focus on the child's experience, leading to overly optimistic judgements on the likelihood of sustained improvement, was evident in some cases. Recent decision-making has been more focused and appropriate and ensured sustained risk reduction. Improvements in the management of child protection conferences, with the use of a nationally recognised model of social work, are supporting the identification of risks and vulnerabilities and the engagement of parents and children. Advocacy is offered to and used by children and young people in child protection processes, enhancing and supporting their ability to participate.

32. Core groups are held regularly. These meetings check progress against actions but do not consistently evaluate risk and amend plans on an ongoing basis. This is hindered by the lack of plans specific enough to support effective measurement of progress and risk reduction. A lack of challenge from core group members, when agencies are not appropriately undertaking agreed work, means that overall risks are not always reduced and needs are not always met in a timely way.
33. A focus on ensuring that the child's voice is heard has underpinned recent improvements. Where poor practice was seen, children's views are not consistently recorded or evidenced, and direct work is not always undertaken when required. In some cases involving siblings, the views and experiences of the individual children are not clearly differentiated. When children and young people have been engaged effectively, their views suitably inform planning and interventions. One young person interviewed as part of this inspection described how he trusted the social worker, describing her as his second mum, and how he felt better in himself as his family life had improved. When children are too young for their views to be gained directly, observations of relationships and presentation are evident. (Recommendation)
34. Children's individualised needs arising from diversity are not fully identified, explored or addressed in the majority of cases seen. This includes needs arising from gender, sexual orientation and faith (Recommendation). Understanding the impact of disability on a child is addressed more effectively in the team that works with children who have disabilities, and individual examples were seen in which a child's background and heritage were positively addressed.
35. When children and young people are at risk of child sexual exploitation, risks are well recognised and successful actions are taken to safeguard them. The multi-agency assessment child sexual exploitation tool monitors young people believed to be at risk of sexual exploitation effectively, ensuring that risks are fully analysed and appropriate action

is taken to reduce risk and inform planning. Responses to sexual exploitation and children who go missing from home, school or care are well coordinated, and there is an effective multi-agency response. There is effective management oversight of trends, which supports a timely response, both individually and in relation to broader risks to children. Children who are identified as frequently going missing receive effective support to manage and reduce risks to them. Return interviews are undertaken by an independent organisation, although notifications to them are not always timely. Consequently, return interviews are not consistently completed within 72 hours.

36. Comprehensive systems are in place for tracking and monitoring the number of children and young people who are home educated. At the time of inspection, there were 163 children and young people being home educated, 59 of primary school age and 104 of secondary school age. Staff support many home educated children's return to the formal education sector. In 2015–16, of the 60 cases of children who ceased to be home educated, 49 returned to school, seven moved out of the area, and four were formally referred on as children missing from education.
37. Too many young people (16 in six months) who present as homeless are placed in bed and breakfast accommodation. While risk assessments of the provision are undertaken, specific risk assessments of the placements of individual young people are not in place, and, although the vast majority of young people are moved on quickly, this evidences a lack of appropriate emergency provision for this age group. Single assessments undertaken when young people present as homeless are thorough and compliant with case law. There is persistent work to engage with young people even when they are reluctant to receive support. (Recommendation)
38. Multi-agency risk assessment conferences have consistent attendance from all appropriate partner agencies, and information relating to children linked to the perpetrator is clearly evident in well-minuted meetings. The MASH team manager appropriately represents children's social care and coordinates information sharing effectively to ensure a timely multi-agency response. A wide range of services support families in which domestic abuse has occurred, and there is a single point of referral to ensure coherent management of cases. Services have been subject to a recent review. No performance information is currently available to evaluate the effectiveness of interventions, although a performance framework has recently been introduced.
39. Sound processes are in place for multi-agency public protection arrangements (MAPPA), and this results in clear assessment of any potential risk to children. However, information from MAPPA meetings is not consistently recorded on social care records. Consequently, risks to children in some cases may not be sufficiently clear.

40. Understanding and awareness of female genital mutilation has been disseminated effectively, evidenced by the number of cases in which female genital mutilation has been addressed. Sensitive but tenacious multi-agency work with families is evident from cases reviewed, supported by the use of translators and offering appropriate challenge, particularly to fathers.
41. Work to identify and prevent violent extremism is well established, with a clear structure and action plan monitored by the Wakefield Together Partnership. The nature of risk is well understood and is primarily linked to far right activity. However, good links and developments with mosques are in place, and there is proactive engagement with local communities. Training for all designated safeguarding leads in schools has taken place in the last year, and there is a school safeguarding policy for the 'Prevent' duty. Individual referrals are routed through and screened by the designated police officer, and individual case examples describe effective and creative work with young people.
42. The number of children identified in private fostering placements has increased, following an awareness raising campaign. The completion of private fostering assessments on current cases is timely, but this has not always been consistently achieved, resulting in delays in assessment of suitability for some children. In the cases sampled by inspectors, children being cared for under these arrangements were appropriately supported, their views were clear and outcomes for them were positive.
43. Robust practice by designated officers, together with timely partnership working, ensure that children and young people are suitably protected when allegations are made against people in positions of trust. Effective communication between agencies and children's social care ensures that children and young people are safeguarded and supported. Analysis of data informs future working, for example planned work with mosques and decisions about where training should be targeted.

<p>The experiences and progress of children looked after and achieving permanence</p>	<p>Requires improvement</p>
<p>Summary</p> <p>Comprehensive services to children on the edge of care assist social workers in supporting children to remain at home. Decisions about whether a child should become looked after are appropriate. Good relationships with the courts and the Children and Family Court Advisory and Support Service (Cafcass) ensure that court processes are well managed and timely.</p> <p>Children’s placement needs are not always sufficiently addressed and, as a result, some children experience a number of placement moves, and the rationale for changes to children’s placement plans is not well recorded. The sufficiency duty is not fully met in relation to emergency or brother and sister placements.</p> <p>Assessments to identify the changing needs of children looked after are not consistently updated to inform current planning, and the voice of the child is not sufficiently evident. However, good priority is given to ensuring that some children can contribute effectively to plans for their futures. The advocacy service provides effective support to children to express their views. When children come into care, contact with immediate family is arranged quickly and is suitably child-focused.</p> <p>Children suitable for adoption receive a good service from the discrete team of experienced professionals. Recruitment and assessment of adopters is handled well, and dedicated and experienced family finders within the service swiftly identify adoptive families for children. Adoption timeliness is improving, although still below government targets, and the impact on the overall figure of unavoidable delay for a very small number of children is well understood. Analysis of the adoption scorecard means that the service is aware of its performance against comparators, but the priority remains to achieve what is in the best interests of the individual child rather than being overly focused on meeting targets to reflect a positive scorecard.</p> <p>Children’s health needs are met effectively through a range of services, including the children looked after health service. Plans to ensure that children have improved access to universal mental health services are in place, and services are improving. However, access to more specialist support through child and adolescent mental health services (CAMHS) is not timely.</p> <p>Children looked after are supported effectively by the virtual school’s multi-disciplinary team to make good progress in education from their often low starting points. The care-leaving service is tenacious in staying in contact with all care leavers to ensure that it continues to support them in making positive choices about their accommodation, training and employment as they progress into adulthood.</p>	

Inspection findings

44. A comprehensive range of services is available to support children to remain with their families and to prevent them from becoming looked after. The intensive family support team and the residential family support team are providing effective support to children on the edge of care and their families, through the offer of planned short breaks, direct work and training for parents in therapeutic crisis intervention.
45. There is improving use of family group conferences to support families. While a sustained reduction in the number of children looked after has not yet been achieved, there has been no increase in the number of children looked after in the last three years. Positive impact of the service is evidenced on an individual case basis, but the local authority has not yet undertaken an analysis of the service and its impact.
46. Appropriate decisions are swiftly made by senior managers for children to become looked after. Timeliness of care proceedings is monitored through the Public Law Outline tracker, and this has recently been enhanced, which has had a positive impact, for example, on ensuring that the duration of the court process remains at approximately 28 weeks. Although not yet meeting the government's target of 26 weeks, it is in line with other local authorities in the area, and some delays are due to court scheduling and are not the fault of the local authority. A positive and productive relationship with Cafcass and the courts enables court processes to be completed effectively. The local authority's legal service is proactive, and it ensures that social work teams are kept well informed of the latest guidance and good practice. In most cases, advice and support on individual cases is clear and effective. Briefings and training sessions on legal changes, court rulings and court skills are provided, as well as case consultation. This is contributing to a timely resolution for children.
47. Case recording and document storage for children looked after are, in most cases, incomplete and confusing. Plans are hard to follow and are not used as working tools to ensure that children are making progress. They do not, therefore, ensure that children are receiving the right support at the right time. The local authority recognises this, and has a working group in place to move towards a model based on a nationally recognised model of social work. Appropriate decision-making for children at the earliest opportunity is not evident through care planning and children looked after reviews. The second review is not used as a milestone to provide clarity for families regarding the permanence options that may be pursued as an alternative to children returning home. (Recommendation)

48. The impact of social workers' visits and direct work with children and young people looked after is not well recorded, and valuable information about their experiences and history could, therefore, be lost. The impact of children's wishes and feelings on planning and decision-making is variable. Children are visited at least within statutory guidance but the local authority lacks robust monitoring mechanisms for the quality and recording of these visits.
49. The local authority strives to place brothers and sisters together when this is assessed as appropriate. A recruitment strategy to attract carers specifically for family groups is in place. However, when brothers and sisters are not placed together, the rationale for this decision is not clearly documented. Some consistency in worker is assured when brothers and sisters are placed apart by the appointment of one IRO for each family group.
50. An appropriate range of legal orders and placement types are sought to ensure that children are in the best placement to meet their needs and to help them achieve permanency. For example, the number of children ceasing to be in care and living with their carers under special guardianship orders (9%) is comparable with statistical neighbours (9%). There is an improving focus on children returning home when it is safe to do so, although this is not yet routinely reviewed as an alternative to permanence for those children who have been looked after for some time. However, return home plans sampled showed that decisions are appropriate and risk assessed and that children and families are supported.
51. When decisions have been made by the agency decision maker (ADM) to place children for adoption, family finding is completely child-focused and led by their needs. A surplus of in-house placements, strong consortium arrangements and a familiarity with the wider market by the highly competent and experienced family finders in the adoption team mean that there is the minimum of delay in finding adoptive placements for children.
52. Children's placement stability and the underpinning sufficiency strategy are poor. According to the council's own figures, the number of children looked after who have had three placement moves or more is 17% in 2015–16 compared with 15% in 2014–15, with the average of statistical neighbours being only 9%. Long-term placement stability, which covers children in a placement for two or more years, has also recently declined from 67% to 61%. Due to the absence of robust management data, an effective strategy to understand and address this is lacking.
(Recommendation)
53. Recruitment of good-quality foster carers is managed by a stable, highly experienced team, led by a strong and effective manager. The majority

of subsequent assessments are completed within the required timescale, and carers report thoroughness, fairness and honesty as significant features of the assessment process. Regular support groups enable foster carers to meet, share expertise, build relationships and offer and receive effective support. Foster carers report positively on their initial contact with the team. Targeted recruitment of carers for teenagers and brother and sister groups has been a focus this year. An increase in viability assessments of connected persons has occurred. However, these developments still do not meet the current demand for placements, and, as a result, some children are placed with external providers outside the local authority area.

54. Arrangements for delegated authority are becoming embedded and they are ensuring that decisions for children are made in a timely way. This recognition of shared responsibility sustains effective communication and validates carers' professional roles. When children are looked after with parental consent, under section 20 of the Children Act 1989, decision-making for them is in some cases unclear. The allocated social worker waits until the child has settled into the placement before ensuring that all written agreements are in place and signed by all parties. This creates uncertainty and a delay in decision-making for the child.
55. Foster carers are supported effectively and receive regular supervision and training to ensure that quality standards are maintained. A system of payments for skills is developing, which carers find encouraging, as this is a recognition of their training and expertise. Training provided to carers is increasingly making constructive use of experienced carers with specific skill-sets, as well as advice from young people recently in the care system.
56. Annual foster carer reviews provide an appropriate opportunity for the carer and supervising social worker to reflect on challenges and to celebrate achievements. However, in 2015–2016, only 77.5% of foster carers' reviews were completed on time. This does not ensure a consistently timely review of ongoing suitability. Recent changes in IRO roles and responsibilities have resulted in a specialist foster carer IRO to tackle this shortfall and to address the concern effectively.
57. Good practice is evident in individual cases of young people staying put with their foster carers beyond their 18th birthdays, and sensitive consideration and handling of diversity needs is evident in individual young people's case recordings. However, an absence of robust data and management information means that the overall impact of the staying put agenda has not been evaluated.
58. Although the majority of children benefit from having their looked after reviews on time, there is a reduction in timeliness on the previous year's performance (from 99.1% to 95.4%). The specialist team working with

children who have special educational needs and/or disabilities delivers a variable quality of work to children looked after because care plans are not consistently reviewed in a timely way. For example, in one case seen, this shortfall has resulted in drift for a vulnerable child with some complex needs, who had remained in an inappropriate placement for too long.

59. Children are supported to attend their reviews and to contribute directly, or are supported by an advocate, although the number of children attending reviews has reduced this year from 95.2% to 89.6%. Parents are less well supported, and advocacy is not used routinely to support them. Social workers' reports to reviews and the subsequent review minutes are often late or absent.
60. Caseloads in the IRO service are above the recommended level (83 as opposed to 70) because of staff vacancies. This is having an impact on the service's ability to monitor children's plans in between reviews and to improve the quality of social work practice. Disputes are formally raised by IROs, and these are reported to senior managers quarterly. However, this has not been effective in resolving the issue of missing social work reports. (Recommendation)
61. Arrangements for children to see their immediate families are well considered and timely. Contact is facilitated effectively by the contact service, social workers and foster carers. However, contact with wider family members, such as half brothers and sisters and step-parents, is not consistently considered.
62. Children with mental health needs who require a referral to CAMHS do not receive the service in a timely way, with some waiting over a year. For children who are looked after, this wait is reduced to three months. Action taken to address this will take time to have an impact, leaving children without a sufficiently responsive service. The emotional health and well-being team supports children, carers and professionals when children's needs do not meet the CAMHS threshold. This service offers face-to-face work and consultation on a range of issues that affect children's mental health and emotional well-being. However, due to staff shortages, this service also operates a waiting list. The development of an online counselling service is one of a number of initiatives planned to address the needs of all children and young people, including those looked after.
63. The health needs of children looked after are considered and met well in the vast majority of cases. The health team has a robust system in place to ensure that there is no delay in initial health assessment and subsequent reviews: 92.8 % of initial health assessments, which represents a high rate, are completed on time, and the reasons behind the minor shortfall are understood. For example, UASC assessments are

delayed until the young people's age is established. The team visits all children within a 50 mile radius, enabling children who move out of the authority to retain the same nurse. It offers a range of preventative health information as well as targeted support to address issues such as sexual health, sexual exploitation, drug use and self-harm. The service also supports young people to access universal services to ensure that children looked after benefit from well-informed services across a range of health needs.

64. When children go missing, they are offered a comprehensive return home interview by a service independent of the council. This service works effectively with partners and offers a valuable and child-focused intervention. However, notification to the provider who conducts return home interviews is not consistently timely, and visits are sometimes delayed. A dedicated multi-disciplinary team ensures that children at risk of child sexual exploitation receive a supportive and swift response. A further attribute of this service is that it ensures that data is captured and used to gather intelligence that prevents or disrupts future incidences.
65. Young people who demonstrate emerging signs of offending behaviour or have become involved with the police are offered a comprehensive service by the youth offending team. A focus on early intervention and prevention, as well as restorative justice, supports young people effectively, and criminalisation is seen as a last resort. Offending rates of children looked after are currently at 7%, which is below average, and reoffending rates are among the lowest in the country.
66. UASC receive a thorough and sensitive service in most cases seen. The social work team that offers this support is able to draw on a specialist worker to guide members through complex immigration issues. Young people have their cultural and heritage needs addressed through a range of services, such as specialist foster placements, education support, dedicated IROs and comprehensive health assessments.
67. The local authority has shown a strong commitment to maintaining the size and effectiveness of its virtual school service, 'REACH'. Managers have invested part of the pupil premium funding to establish four learning mentors, who provide intensive support to children looked after, to improve their literacy and numeracy skills.
68. Managers rigorously monitor and track the progress of children through a system of fortnightly meetings that risk rate children looked after, based on their attainment, attendance and behaviour. Managers assign follow-up interventions to specific members of staff. As a result, there has been a steady improvement in the progress that children looked after make, based on their often low starting points, with the great majority (88%) expected to achieve their progress target in 2015–16.

69. Despite the steady progress in the attainment of children looked after, there are still significant variations at different key stages and from year to year, depending on the size of the cohort and the proportion of pupils with special educational needs and/or disabilities. In 2014–15, the gap in attainment between children looked after and their peers in the rest of the borough widened at key stage 1, reduced at key stage 2 and widened for those achieving five GCSEs at grades A* to C, including English and mathematics. However, over the past five years, the gap between children looked after and their peers has gradually closed.
70. The percentage of children looked after in good or better schools, as rated by Ofsted, has steadily increased over the past few years, from 55% in July 2014 to 76% currently. In the interests of stability, children looked after are not automatically removed from schools where the quality of provision declines, but managers put in additional support to ensure that the impact on their progress is minimised.
71. The great majority of personal education plans (PEPs) provide an effective means of planning the education of children looked after and of setting them specific and realistic targets to enable them to progress. There has been a significant improvement in both their coverage and the timeliness of their completion. Currently, all children looked after have a PEP, compared to only half of them a few years ago. The plans successfully mobilise the interventions and resources of a broad range of agencies to support the all-round development of children looked after. Managers use the plans well to specify how the pupil premium should be spent to meet the needs of individual children. In the minority of less successful PEPs, there are gaps in information and the targets are less than ambitious.
72. There are currently 20 children looked after in alternative education provision: eight in two of the three pupil referral units, and 12 with a range of other providers, including the local further education college that offers general provision. All children looked after and young people in alternative education receive at least 25 hours of education a week. Local authority staff rigorously monitor the quality of the alternative provision and track the progress of all students at alternative providers, using the same systems as those used to monitor those in mainstream provision.
73. A vibrant Children in Care Council promotes good participation and represents children and young people well, including children placed out of the area. Children and young people say that they feel listened to and can make a good contribution to improving services for children looked after. One young person said, 'I like being part of decision-making.' Those spoken to are confident that any issues raised will be addressed, for example awareness of bullying issues. Another young person said of the local authority, 'They are doing all right, so everyone is safe.' The

council's website for children looked after, 'Care 4 Us', holds useful information but has not been updated since 2015.

74. Inspectors saw many children benefiting from an effective advocacy service. All children looked after who are aged 10 years and over, have access to an advocate commissioned from a national voluntary organisation. One parent spoken to by inspectors commented that this had really helped her daughter to put forward her views. The service visits young people when they arrive in care, to ensure that they know why they are being looked after and what support is available to them. Children's views are sought to inform service developments when placements come to an end. There is an effective independent visitor service, providing support to 22 young people currently.
75. The family drug alcohol court is an exciting and proactive project, which is in its first, pilot year. This innovative approach uses care proceedings to motivate parents to engage with treatment for their substance misuse and to improve their parenting. Multi-disciplinary support is provided, with a focus on the whole family. This means that fewer cases become contested hearings. Consequently, if a parent cannot control their substance misuse, children are placed in a permanent alternative family swiftly. A dedicated multi-disciplinary team works alongside two designated judges, and, as a result, families know all of the professionals involved in their lives, including the judiciary, extremely well. This provides families with a sense of security within nurturing, yet firm and consistent, boundaries. The passion and enthusiasm of all of the team is evident. This level of commitment provides all of the participating families with every opportunity for success.

The graded judgement for adoption performance is that it is good.

76. A highly experienced and dedicated adoption team delivers a good and in parts excellent specialist social work service to children. Adoption processes, such as ADM meetings and adoption panels, are efficiently run. The use of the service's working lists to extract data and complete an accurate adoption scorecard means that this service has some limited access to comparative performance information. However, the driving force of the service is to meet the individual placement needs of children.
77. Adoption is appropriately considered, either as the plan for permanence or as a parallel plan for all children of a suitable age going through care proceedings. However, this does not happen quickly enough in some cases. According to the latest published figures, 25% of children looked after leave the council's care through adoption, and this is better performance than their statistical neighbours at 23% and the all-England average of 17%. Co-allocation, at an early stage, of experienced

adoption workers with placing social workers means that adoption processes are rigorously adhered to. When the plan for adoption becomes the plan for permanence it can, therefore, proceed without delay. Co-allocation has also led to a recognised improvement in the quality of child placement reports, as experienced adoption team members assist and enable placing social workers to complete their reports for panel well.

78. Marketing aimed at increasing the pool of in-house adopters is undertaken effectively by a dedicated events coordinator in the adoption team. The team works closely with a neighbouring authority in preparation training for prospective adopters. The agency's latest figures show that conversion rates from enquiries to placements are relatively high, at a fifth to a quarter, and this has resulted in a surplus of adoptive families, so that placing social workers can currently be offered a choice of in-house adoptive families for children. The surplus adopters are shared across the consortium. Sympathetic matching of children's diverse needs is assured, both by strong consortium relationships within West Yorkshire and Humberside with authorities who have more diverse populations, and use of the adoption register when required.
79. Prospective adopters are thoroughly assessed and well trained by designated assessment workers within the adoption service, who are highly skilled professionals. The low number of disruptions, three in five years, demonstrates that assessment and training of adopters are secure. Reasons for disruptions are understood well, and most commonly occur for older children when there has been a risk of breakdown at the time of placement. The adoption team responds early to provide a range of support services to families at risk of disruption. According to the latest published figures, the service for placing children over five years old is at 10% and performs above their statistical neighbours (7%) and the all-England average (5%). However, the service understands well that placement for adoption of older children carries risks from their prior parenting experiences, and this can lead directly to disruption.
80. The latest published figures relating to the time taken between receiving court authority to place a child for adoption and matching them with prospective adopters has missed government targets by 72 days. The adoption agency's more recent figures, taken from its annual report, show that this has reduced to 48 days in 2015–16, but the report acknowledges that it has dropped from ranking first against comparators to fifth. When delay occurs, the reason for it is well understood and is usually outside of the adoption team's control. For instance, there are current delays associated with a complex international adoption.
81. When the plan for adoption has changed to an alternative plan for permanence, latest published figures show that the service, at 12%, performs better than the statistical neighbour and all-England averages

of 19% and 14% respectively. Scrutiny of the two relevant cases that fall within the scope of this inspection demonstrates that changes to the plan have been made as a result of decisions by the court, and again these were outside of the adoption team's control. When there was subsequent delay in the plan for permanence, IROs were seen to challenge social workers robustly on behalf of the children.

82. Placement choice has recently been further enhanced by the introduction of fostering-to-adopt placements, although the team is aware that the success of such placements, of which there have been four so far, has been variable. It uses a process of team away-days to extract the learning from specific issues, and one is planned to look at how the consistency of fostering-to-adopt placements can be better assured.
83. Parental assessment reports (PAR) produced by designated and highly skilled adoption team members can be of an excellent quality, and they are a significant strength of the service. Adopters spoken to or surveyed were highly satisfied with the service that they received. Under circumstances of high demand, the assessment service is supplemented by a contract with a private social work agency. The agency allocates assessments to a defined group of social workers who are vetted to meet adoption regulations, and the agency employs its own assurance processes to ensure that the quality of the PARs presented to panel is consistently high.
84. A highly competent adoption team manager, who acts as panel adviser, very efficiently administers the ADM and panel processes. Items of business are rigorously quality controlled, although both the panel and the ADM can offer examples of appropriate challenge. Scrutiny of panel minutes indicates that it is currently vigorously pursuing a priority of improving the quality of written support plans presented to panel at matching stage. The ADM observably acts in the best interests of the child. For instance, in the case of an international adoption, he refused to sign off the plan for adoption until the child's country of origin had been contacted, notwithstanding the negative impact that this has had on adoption timeliness overall.
85. Post-adoption support work is undertaken by three specialists in the adoption team who work with adopters post order, but are visible throughout the preparation stage. The team currently supports 35 children in 24 placements. Staff are proactive in ensuring that adopters are aware of the support available to them and that this is provided to individual families, when requested, at a mutually agreed level. Support workers usually work with families for three years post adoption, but are flexible when ongoing need is identified. Effective and imaginative use is extensively made of the adoption support fund to reinforce post-adoption plans. This development is drawn from the lessons learned from previous

disruptions, particularly by funding families' access to therapeutic support.

86. A quarterly post-adoption newsletter, with contributions from adopters, has helpful information about the adoption support fund, training opportunities, an adopters' toddler group and the adoption peer support group. Later-life letters of five children looked at were detailed and suitably tailored to the children's individual needs. Following a lapse due to a staff vacancy, letterbox arrangements are now being appropriately administered. Four life story books seen were of high quality, capturing the children's experiences in several creative ways, although they were not always started promptly. (Recommendation)

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

87. The experience and progress of care leavers is good. Managers, social workers and personal advisers are tenacious in staying in contact with all care leavers, to ensure that they continue to support them in making positive choices about their accommodation, training and employment as they progress into adulthood. Care leavers have a strong sense of their entitlements and participate well in shaping the future delivery of the service. Managers and their staff engage effectively with other agencies to plan positive outcomes for care leavers.
88. Managers and staff are in contact with all 225 care leavers, with the result that they have good information on their accommodation and progress in education, training and employment. Personal advisers and social workers use an effective mixture of rewards, such as birthday grants and contacts with other agencies, for example the police and the youth offending team, and their local intelligence to locate the few care leavers from whom they have not heard for a couple of weeks. There are well-established relationships and information protocols with neighbouring local authorities that swiftly alert personal advisers and social workers when care leavers go missing.
89. The majority of pathway plans focus effectively on supporting care leavers to achieve positive outcomes. Personal advisers and social workers engage young people well in the development of their plans, and are effective in ensuring that the relevant agencies contribute to the process. Planning is particularly strong in supporting care leavers' progression through education and training, and in finding solutions to their changing accommodation needs. Personal advisers and social workers pay close attention to monitoring risky behaviours and intervene, when necessary, to keep care leavers safe. However, due to

recent pressures on management capacity, there have been a number of transition pathway plans that have not been completed on time.

90. Transition planning for young people with learning difficulties and/or disabilities is carried out skilfully, with a good focus on the achievement of long-term positive outcomes. Planning starts early, with the engagement of adult services, and involves young people in all the main decisions. Care packages are personalised to meet the specific needs of individuals. An increasing number of young people now have education, health and care plans, which contain specific and realistic target outcomes that are a significant improvement on the targets contained in the previous learning disability assessments.
91. The proportion of care leavers living in suitable accommodation has increased over the past two years, with the result that it is now higher than both statistical neighbours and the rest of the country. There are no care leavers in bed and breakfast accommodation. However, the situation could be further improved if the relationship between the leaving care service and Wakefield's arm's-length housing provider was more effective. Due to a lack of direct joint working, the care service has seen the number of tenancies allocated to it drop from 10 to three over the past few years, with the result that there has been a reduction in the accommodation options open to care leavers. (Recommendation)
92. The percentage of care leavers in education, employment and training in 2014–15 was 52%, four percentage points higher than the figure for both statistical neighbours and the rest of the country. Care-leaving staff work very effectively with educational providers in the area to identify courses for care leavers and then to support them through the enrolment process. Teaching and support staff provide regular updates on the progress of care leavers, to inform pathway plans, and remedial actions are agreed and implemented if care leavers do not make sufficient progress or are at risk of dropping out. Managers in local further education colleges provide care leavers with additional learner support and bursaries to help them to overcome any barriers to their learning.
93. In 2015–16, there was a slight increase in the percentage of care leavers who were not in education, employment or training due to the withdrawal of a co-located information, advice and guidance service. Managers have reacted quickly to establish their own weekly drop-ins to advise care leavers about their training and employment options, and to assist them with job search and the writing of curricula vitae.
94. Personal advisers successfully support many care leavers in the transition to adulthood, through a succession of well-planned stages in the development of their independent living skills. Care leavers progress from taster flats in supported accommodation through shared accommodation, where they are increasingly responsible for the payment

of rent and utility bills, until they secure their own independent tenancies. Care leavers are given a second chance if their tenancies break down, and receive additional support to help them to succeed the next time.

95. Staff provide care leavers with summaries of their health records when they are 16 years old, and then again when they turn 18. The great majority of them know that they are registered with their local doctor and dentist, and are confident about how to access other health services. Personal advisers provide effective information and practical ideas about how to stay healthy, such as the 'cook and eat' sessions to promote a good diet. There are, however, long delays in getting access to therapeutic support and access to both adolescent and adult mental health services.
96. The care leavers' pledge is a strong statement of the council's commitment to its role as a corporate parent and sets out in clear language what care leavers can expect in terms of their entitlements and ways in which the council will support them. However, the pledge's usefulness is seriously undermined by the promotion of a dedicated website, where care leavers are supposed to be able to access up-to-date information about what they are entitled to and events that they can participate in, but which has not been updated for over a year.
97. The majority of care leavers understand what their entitlements are, and many of them take them up, in particular the grant to help them to set up home in new accommodation. They are aware of the continuing support available to them if they want to stay in, or return to, education up to the age of 25. There are currently 13 care leavers in higher education. Although staff use a range of mechanisms to ensure that care leavers are informed of their entitlements, the most common way that care leavers find out about what is available is through word of mouth from their peers.
98. The post-16 care leavers' forum provides a useful vehicle for care leavers to meet with managers to express their issues and concerns, and to work on joint projects. Although attendance is variable, care leavers in the forum have successfully put forward their ideas about the type and range of accommodation they would like to see developed, and the facilities they would like improved, such as access to the internet and improvements in the security of the flats in supported accommodation.
99. Staff ensure that care leavers feel positive about their progress and achievements. An annual awards' night is supplemented by one-off events to celebrate specific accomplishments, such as the awarding of a specially commissioned medal for a care leaver with a physical disability, who completed a local marathon.

100. Recent reductions in management capacity and staffing, combined with uncertainties created by the current review of the leaving-care service, have resulted in some deterioration in the quality of service delivery, such as the completion of pathway plans within agreed timescales, and the implementation of new developments, such as the new supported accommodation and the apprenticeship programme.

Leadership, management and governance	Requires improvement
<p>Summary</p> <p>Senior managers, political leaders and partner agencies are highly committed to improving outcomes for children and they demonstrate a clear understanding and passion for their roles.</p> <p>The local authority has delivered improvements since the last Ofsted inspection in 2012, when the authority received an adequate rating. Senior leaders and elected members have worked closely with partner agencies to improve the delivery of services for the children and young people in the authority. However, progress in some areas has been slow and the local authority recognises that more work is needed to ensure that practice is consistently good.</p> <p>The newly established performance cycle is not yet effective because the absence of effective performance management systems and lack of confidence in the local authority's own data inhibit the ability to make more significant progress. This current key priority is impeding progress in all areas.</p> <p>An appropriate focus on early help and front-door arrangements has led to tangible improvements in service delivery, and the investment in early help means that children and families are receiving the right level of intervention at the right time.</p> <p>Strong strategic arrangements to safeguard children and young people who go missing or are at risk of sexual exploitation ensure that children and young people identified as being at risk receive a swift and timely operational response.</p> <p>A full quality assurance culture is not yet evident, and, although this is improving, supervision and management oversight of social work practice does not always help to drive improvements in practice. The children's database is not currently meeting performance management requirements, and the local authority is aware that it needs to make decisions about how this can be resolved.</p> <p>The workloads of some social workers, frontline managers and IROs are too high, which is having an impact on their ability to provide a high-quality social work service.</p> <p>The local authority is not meeting its sufficiency duty, and, in the absence of accurate data, senior managers do not have a comprehensive oversight of placement needs, which has had an impact on placement stability.</p> <p>A well-managed nationally recognised model of social work is delivered as part of the national innovations fund project and, although practice is not yet consistent, it is used widely across the authority.</p>	

Inspection findings

101. The Ofsted inspection of 2012 has been a significant driving force in a wide range of improvement planning and activity. The appointment of the current DCS led the way for a significant cultural change in the children services directorate, and, following a complete restructure of the senior management team, his vision has driven improvements in services to children and their families effectively. The local authority is well aware that, although action has been taken to improve services, progress in some areas has so far been slow.
102. Strategic thinking in Wakefield is strong, but this has not yet been translated into effective planning in all areas. There is a shared vision with many partner agencies and a clear ambition for the children and young people in the district. This ambition benefits from the full support of the chief executive and elected members, who promote and embrace the vision, demonstrating a real passion and knowledge about improving outcomes for all children.
103. Appropriate and clear governance arrangements between key strategic bodies, overseen and coordinated by the Wakefield Together Partnership, including the Children and Young People's Partnership, the Health and Wellbeing Board (HWB), the overview and scrutiny committee and the LSCB, are evident. Strengthened partnership arrangements promote the sharing of priorities and encourage helpful communication about key issues. Relationships between the leader of the council, the lead member, the chief executive, the DCS, the LSCB chair and elected members enable strategic and political leaders to maintain an overview of the effectiveness of services to children, young people and their families.
104. Clear strategic connectivity is in place between the multi-agency partnerships' plans, including the children's and young people's plan, and they are aligned to the priorities identified in the district outcomes framework (DOF). The local services board, chaired by the leader of the council, ensures that plans are progressing and appropriately holds partnerships to account.
105. A dedicated children's joint strategic needs analysis (JSNA) includes an appropriate range and level of detail about children, including vulnerable children. The HWB has appropriately used the JSNA to consider its priorities, and there is a current focus on mental health, including addressing the specific needs of children and young people. The board is operating effectively in terms of overseeing the HWB plan but it does not always focus on children, including children looked after. The chair is aware of this and has recently undertaken a joint development session with the LSCB to help to integrate the agendas.

106. Although the overview and scrutiny committee does not receive regular data to help to inform its challenge, the committee is nevertheless active in ensuring that there is regular overview and monitoring of practice across health, education and social care. It has appropriate links with the LSCB and, when determining the work programme, uses the DOF to ensure that there is a focus on the partnership priorities. The board is using its scrutiny and exerting its influence in key areas, including a continued focus on child sexual exploitation and early-help hubs, but it does not receive broad enough performance information to decide which issues would benefit from additional scrutiny.
107. Following a directorate review, children’s performance management has been comprehensively overhauled. Team structures have been clarified, and there is now a designated children’s performance team. A clear performance cycle has been established, and this is underpinned by a satisfactory quality assurance framework that is, in turn, supported by a range of tools, such as audit tools, to promote effective performance. Audits are routinely undertaken, using clear methodology, and this contributes significantly to management oversight of specific cases. However, more could be done to capture the learning from audits as a whole and to use it as part of the overall improvement agenda. Adoption of the framework could potentially support the delivery of a wide-ranging set of quality assurance processes. However, performance managers are aware that they have not yet secured the hearts and minds of managers to a performance culture. (Recommendation)
108. Absence of accurate data means that performance reporting is seriously underdeveloped across the full range of children’s services, although some services are more affected than others by this deficit. Organisational commitment to improve the accuracy of staff inputting to the electronic recording system has not yet materialised to any significant extent, and this creates a vicious circle in which management reports are generally mistrusted when they are produced from data input by the members of staff who mistrust them. In addition, confidence in the current system to deliver the requirements needed for effective performance management is not assured. Consequently, managers have developed their own bespoke systems to address this situation, in order to ensure that they understand performance in their own teams. Such circumstances lead to a situation in which managers are generally unaware of their performance against comparators, and the capacity of managers to drive improvement across services is seriously inhibited. This also inhibits senior managers’ and elected members’ overview of the services. (Recommendation)
109. Senior managers and political leaders demonstrate a strong commitment to external scrutiny and challenge, shown by their engagement with a number of external reviews in order to help to improve services. The use of one such review to help to drive forward improvements to the

management of contact and referral processes is showing some early signs of success, and the associated transformation plan is innovative in relation to tackling some key issues in relation to value for money and making improvements.

110. The local authority actively seeks opportunities to further develop services and is often recognised and rewarded for such endeavours. This includes involvement in the national pilot of a nationally recognised model of social work, delivered as part of the innovations fund project. The project's outcomes and progress towards them are therefore clearly identified, and the project managers are fully aware of, and able to articulate, the vision and current position. Their endeavours have been recognised through an award from the trade press. A substantial training programme has been delivered to a high number of staff. Cases offered as good-practice examples demonstrate that, when used effectively, the model can add significant value to assessment and planning processes by clearly expressing concerns and solutions in a way that is accessible and understandable to parents. However, the project's integral audit process means that managers are aware that practice in using the model is not yet consistent, and this is planned to be addressed by the next phase of the project.
111. A history of involvement in a range of consortium initiatives means that the region is well placed to take full advantage of the regional agenda. Active membership of the West Yorkshire and Humberside consortium means that Wakefield's adoption service is a key participant in forthcoming regional adoption arrangements. These are currently in transition, with an implementation date set for 1 April 2017.
112. The local authority uses information, to some degree, about the needs of local communities to inform its commissioning arrangements. Underpinned by a commissioning strategy, the alignment of priorities with the shared strategic objectives is evident. Accurate data would further support this work. The local authority has clear arrangements for commissioning external placements and is involved in the regional framework for the monitoring of such placements, helping to ensure high-quality placement options across the region. Despite deficiencies in data information, the local authority has been able to identify need based on current and predicted need and has developed a pilot 0–5 edge-of-care scheme to reduce the number of young children who need to be looked after.
113. While there is clear commitment to corporate parenting and meeting the needs of children looked after, the local authority has not met its sufficiency duty. There has been no consideration of the high use of bed and breakfast accommodation as part of the sufficiency strategy, in line with the lack of emergency accommodation for children and young

people when they come into care, to ensure that the current deterioration in placement stability is mitigated.

114. All staff spoken to during this inspection spoke very positively about working for Wakefield and identified the visibility and support of their senior managers as a strength. As a result, social worker turnover rates have reduced overall in the last three years from 17% in 2013–14 to 15.4% in 2015–16. A range of targeted recruitment and retention initiatives have led to a decrease in the use of agency staff (67 in 2014–15 and 16 in 2015–16).
115. Caseloads remain variable across the authority, with some workers, particularly in the locality teams, carrying unacceptably high numbers of cases. The local authority has taken steps to remedy this by recruiting above establishment, with additional social workers employed to address the pressures, particularly in the assessment teams, which means that most cases are now allocated within a week of transfer. No children were found to be unsafe because of high caseloads, and effective monitoring of such cases takes place.
116. Capacity issues in the independent review service have led to caseloads being above the recommended level, which has limited IROs' ability to challenge care plans effectively and to ensure that they are progressed in a timely way. When IROs raise issues, senior managers receive reports quarterly. However, this has been ineffective at improving performance in relation to the continued lack of social work reports for statutory meetings.
117. The learning and development strategy clearly sets out the aspiration for the workforce and ways in which the local authority plans to achieve this. The dedicated training team has more recently acquired responsibility for the development and delivery of training for the entire council children's workforce, which enables consistency and opportunity for shared training. Effective use of the budget ensures a sufficiency of training for the identified training pathways of each role. The strategy offers an appropriate focus on statutory and mandatory training, using a mix of commissioned and in-house training as well as e-learning, but offers little in the way of innovative and bespoke packages. The planned training needs analysis will ensure that there is a better understanding of future training needs and of the potential need for more specialist training. The integrated workforce development strategy has not yet progressed. This means that valuable opportunities for joint learning among partner agencies have not yet happened. Close working with the LSCB training sub-committee also ensures that there is no duplication of training and that all safeguarding training provides consistent messages. This includes learning from serious case reviews.

118. A comprehensive support package is evident for newly qualified social workers in their first assessed and supported year in employment, which includes dedicated support staff and regular workshops to supplement the training programme. Policies outline appropriate caseloads and supervision frequency, but evidence seen during case tracking identifies that they are not always adhered to.
119. The role of principal social worker (PSW) adds value to improved social work practice. For example, the PSW leads a thematic monthly meeting of principal social work practitioners in the teams, with the aim of improving the consistency of practice.
120. The local authority has invested in an innovative, corporate 'Performing for Wakefield' management programme, the aim of which is to assist managers in managing performance and to provide them with the tools to do so, in order to support staff to deliver quality practice. Although feedback was positive, managers said that they would need more capacity so that the impact of this targeted training can be realised and to promote a culture of effective quality assurance further.
121. A comprehensive supervision policy is appropriately focused on supporting and developing practitioners, but does not always reflect what is happening in social work teams. Social work staff report, and inspectors found, that supervision is regular in the majority of cases, but the recording of sessions is poor and there is little evidence of an impact on helping to progress plans. Managers are not consistently contributing to raising practice standards. Cases considered by inspectors during this inspection identified weaknesses in management oversight and decision-making, particularly in relation to assessments and influencing the progression of plans for children. Senior managers are aware of these weaknesses and are taking appropriate steps to improve practice through training and targeted recruitment.
122. Positive working relationships with Cafcass include attendance at key meetings and effective participation in the Local Family Justice Board. Cafcass is positive about the quality and timeliness of work presented by the local authority in court work.
123. Effective arrangements to address the needs of young people at risk of child sexual exploitation are supported by the joint West Yorkshire partnerships and at a local level through the LSCB. These arrangements promote the coordination of a range of strategic and operational forums that deliver the appropriately focused Wakefield multi-agency strategy and action plan. Partners and senior and political leaders work together well to understand the prevalence of child sexual exploitation and to establish effective ways of overseeing and reducing local need and risk. Operationally, joint working with the police at the front door ensures early identification of young people who may be at risk. The use of

detailed and targeted risk assessments means that children who go missing or are at risk of sexual exploitation receive appropriate and timely interventions and persistent monitoring to reduce risks.

124. Wakefield has a high-quality and efficient complaints service where children's views are treated with respect, and special attention is paid to their complaints, resulting in the vast majority being satisfactorily resolved at the earliest stages. All complaints and their outcomes are tracked effectively, and the officers provide strong internal challenge through their oversight and tracking of individual complaints, leading to learning from complaints being seen by senior managers as crucial to improving the services offered.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is good.

Executive summary

Wakefield and District Safeguarding Children Board meets its statutory responsibilities, and there are effective links with other local strategic bodies, with good work undertaken to clarify respective roles and responsibilities. The board's work is widely reported via its annual report, and driven by appropriate strategic priorities set out in a clear business plan. Chairing of the board's sub-committees is shared across partner agencies, demonstrating a shared commitment towards safeguarding.

The board benefits from an effective independent chair. Regular meetings with key senior officers, such as the chief executive and the DCS, ensure that they are kept up to date with the board's progress, but not all meetings are currently being minuted. The board has good support from elected members, particularly the lead member for children's services.

Robust challenge from the board has resulted in improved services for children, such as the development of effective early-help services across agencies. Findings from SCRs, critical incident reviews and case auditing are considered in depth. Agencies' action plans are overseen to ensure full implementation and maintenance of improvements. Up-to-date safeguarding procedures are aligned across the West Yorkshire region, when possible, and are supplemented by local protocols and guidance, when necessary. Referral pathways and thresholds are clearly defined.

There is effective oversight and monitoring of early help. Detailed regular scrutiny of early help arrangements ensures that board members are clear about the development of the early-help hubs and the effectiveness of this support for families. Thresholds between early help and statutory services have been directly tested by board members, through visits to the hubs, meetings with families and auditing cases. Findings and recommendations are tracked.

Oversight of arrangements to tackle child sexual exploitation and children and young people who go missing are robust. Effective partnership working across the region is further improving the coordination of responses, and the cross-boundary nature of these concerns is fully recognised.

Regular scrutiny of performance data occurs, but this has been hampered by incomplete provision of data from partner agencies. Good work has enabled a core multi-agency dataset and reporting cycle to be developed to ensure better-quality performance information. The board facilitates a wide range of appropriate well-attended training events.

<h2>Recommendations</h2>

- 125. Ensure that there is sufficient support provided by the board's business unit to enable all meetings to be well recorded and progress to be set out against actions, so that all members can be held to account for their respective responsibilities and there are clear audit trails of sub-committee activity and impact.
- 126. Ensure that the board's business plan and challenge and risks logs are kept up to date, so that board members always have a clear understanding of the board's position and can measure impact, ensure sufficient challenge, and mitigate risks when necessary.
- 127. Ensure that the board continues to make every effort to secure representation from agencies who do not regularly attend meetings.
- 128. Improve the understanding of the effectiveness of multi-agency safeguarding training needs, so that future training plans are able to target training where it is needed the most and where it will have the greatest impact. Consideration should be given to accrediting trainers and participants in the voluntary sector to enhance their contribution.

Inspection findings – the Local Safeguarding Children Board

- 129. Wakefield and District Safeguarding Children Board is an active and effective coordinating body. Agencies who work with children and families come together and are committed to driving forward improvements in services and outcomes for children and young people. Partner agencies make appropriate financial contributions. Levels of attendance by senior leaders are high, and the sub-committees are active and effective. Agencies, such as Cafcass and adult criminal justice agencies, are unable to attend board meetings, but their absence is pursued by the chair. The board has influence beyond the local authority area and has been a leader in coordinating matters such as arrangements to tackle child sexual exploitation across West Yorkshire. (Recommendation)
- 130. The board is properly constituted and is chaired by an experienced and suitably qualified independent person. Robust contract and appraisal arrangements are in place. The chair meets regularly with a range of strategic leaders, including officers and elected members, in the local authority and has regular meetings with the DCS, although it is a shortfall that the meetings with the DCS are not minuted. An independent audit of board functioning in October 2015 confirms that appropriate standards are in place and that there is compliance with statutory requirements. The board benefits from having two lay

members, each representing specific community interests.
(Recommendation)

131. Arrangements between the HWB, the community safety partnership, the adult safeguarding board and this board are well established and effective, underpinned by protocols and pathways. Good work has been undertaken to clarify respective responsibilities and accountabilities, and to differentiate these from challenge duties. Close liaison has led to joint initiatives, such as training on domestic abuse, sponsored by this board and the community safety partnership. As one of a number of joint events, the adult safeguarding board and this board convened a development session in June 2016 to explore areas of common interest. There are good links with the West Yorkshire office of the police and crime commissioner.
132. The annual report covers all key areas and is presented to a wide variety of senior staff and influential bodies, including the DCS, the chief executive of the council, the leader of the council, the police and crime commissioner, the director of public health, the HWB, the Local Services Board and the clinical commissioning group. Elected members are well appraised of the work of the board, as the annual report is also shared with the children's and young people's scrutiny committee, and the lead member for children's services observes all board meetings and attends board events.
133. The board's strategic priorities, appropriately based on an up-to-date needs analysis, are also informed by findings from SCRs and critical incidents. Priorities are aligned with those of other strategic bodies. The business plan is clear, but has not been updated in recent months. Administrative difficulties have had an impact on the maintenance of previously detailed challenge and risk logs and on the quality of the records of some meetings. This makes it difficult to establish the content of, and subsequent actions from, those meetings. Despite this, the challenge log provides a good summary of matters raised up to February 2016 when, for example, the issue of sufficiency of health visitors was raised. Challenge can be seen since February in both main board and sub-committee minutes. (Recommendation)
134. Minutes of meetings demonstrate that board members routinely question each other about their performance and functioning. The board commissions audits and requests partners to provide assurance on specific issues, for example requesting and receiving assurance on a local paediatric fracture clinic. Section 11 audits, in which individual agencies are required to provide assurance of their safeguarding arrangements, are held annually. Self-assessments are critiqued by multi-agency challenge panels, which include trained young people, and this is a strength. Shortfalls are followed until satisfactory standards are achieved. All schools have completed a section 175 survey,

demonstrating willingness to share information about safeguarding arrangements. The safeguarding education adviser follows up when schools have identified areas where they need to improve. For example, some schools identified a need to support lesbian, gay, bisexual and transgender (LGBT) pupils better and were given appropriate advice and signposted to suitable resources.

135. Twice-yearly joint audits undertaken by the audit sub-committee have generated learning, which is disseminated across the partnership and used to inform future priorities. Topics have included peer-on-peer domestic abuse and child sexual exploitation. Although the joint audit process is good, difficulties in administrative support and some methodological weaknesses have limited their learning, but these have helped the board to improve its approach. Additional assurance of practice is sought by board members visiting frontline services and engaging in 'safeguarding conversations' with practitioners. Visits to social work teams, the multi-agency safeguarding hub and early help teams have occurred, and findings have been disseminated appropriately.
136. The board has undertaken SCRs in all instances where the criteria are met and it is positive that none has been required since 2012. The board is robust in checking that partner agencies continue to make progress against the recommendations and makes good use of annual challenge panels to do this. Significant improvements have occurred as a result of SCRs, such as a new hospital children's fracture clinic, new hospital emergency department arrangements for identifying and responding to pregnant women experiencing domestic abuse, the Foreign and Commonwealth Office amending its guidance so that consular officers respond better to situations in which children may be at risk, and there are now good links between general practitioners and health visiting services.
137. The SCR sub-committee gives careful consideration to all new referrals, with two children considered in September 2015 and two considered in March 2016. None of these led to SCRs, but the alternative courses of action decided upon were appropriate. The sub-committee lacks representation from the National Probation Service or the local community rehabilitation company. However, some assurance that communications channels are effective is provided, as one referral to the sub-committee came from adult offender services as a serious further offence notification.
138. The board has been proactive in inviting external scrutiny and challenge, with the aim of improving its arrangements and effectiveness. This includes inviting the council's audit service to review arrangements published in October 2015, and a peer review took place earlier in the year. These confirmed that the board was functioning well and identified

areas of improvement. Recommendations have been acted on swiftly to further strengthen arrangements.

139. There is good oversight of early-help services, which have been significantly reshaped. Early help was the topic of the board's development session in January 2016. Further scrutiny has been achieved by direct visits, an audit of early-help cases, and talking directly with families in receipt of early-help services. Regular performance data on early help will be presented to the board. However, this is currently measuring quantitative data and does not yet include qualitative measures.
140. There is strong oversight of operational responses to child sexual exploitation and children who go missing. The child sexual exploitation and missing sub-committee oversees multi-agency arrangements and receives reports from the regular operational meetings. The chair, in his substantive role, has regular meetings with other strategic leaders involved in tackling child sexual exploitation, including the police superintendent, the clinical commission group's safeguarding lead, the service director for the locality hubs and a national charity. This helps to keep the sub-committee abreast of rapidly developing issues. Members have visited the specialist team and checked on individual case oversight arrangements. Investigations into legacy cases which may have involved child sexual exploitation have led to a number of perpetrators being successfully prosecuted. There is a robust and tenacious approach to licencing arrangements with private taxi drivers, culminating in a significant number not having their licences renewed.
141. A wide variety of relevant training is provided. Its reach, in terms of the number of practitioners who access training, is impressive and strongly multi-agency. Training is rolled out in a variety of ways and includes many events scheduled during the 'safeguarding week' in February 2016. Learning from SCRs informs the training plan appropriately. For example, training regarding signs of injury in non-mobile infants has been extensively rolled out to health professionals and others. The quality of multi-agency training has been checked by direct observation from the training coordinator. Information about partners' future training needs was gathered at a 'training challenge' event in April 2016, to inform the future training plan. While immediate feedback from attendees on training courses is sought, the board recognises the need to improve its understanding of longer-term impact. The current training strategy is brief and lacks sufficient detail on what the desired outcomes of the training are. Some areas have been under-developed because of lag elsewhere. For example, training on neglect is planned, but this has not occurred because the neglect strategy and toolkit have only recently been agreed and finalised. Safeguarding training in the voluntary sector does not benefit from formal accreditation for the deliverers or the

participants, and this is an area for development in the future.
(Recommendation)

142. The annual report (2014–15) is heavily orientated towards commenting on children’s social care performance and less on partner agencies’ performance. The board has suffered from a lack of regular, good-quality performance data to measure services. Performance scorecards were developed but these were not consistently well populated. Some data from children’s social care is acknowledged by local authority performance staff to be historically inaccurate because of software-generated counting issues. This further undermines the confidence that the board has had in the data it received. The board challenged agencies about their data, but it remains a long-standing difficulty in children’s social care. However, performance reporting arrangements have recently improved, and there is now an agreed core multi-agency dataset, which has been populated by all partner agencies. This is properly validated and checked, illustrates performance over time and provides a narrative explaining what the data means. This is a good achievement, but the development period has been lengthy.
143. Young people heavily influence board activities, and this is a strength. Examples include the production of a young person-friendly version of the annual report, and young people’s participation on section 11 challenge panels. Board members have engaged in three ‘listening to you’ events since 2014, with a good range of young people, the vast majority having experience of statutory services. An innovative young people-led ‘safeguarding charter’ has been developed, which sets out clear promises about what the board will deliver for and to young people. The charter, formally launched in May 2016, continues to be widely disseminated, including in schools, and 21 young people have been trained as peer facilitators to explain the charter to other young people. Young people have been heavily involved in the design of other important materials, such as posters and leaflets and including web-based materials targeted at young people to warn them of the dangers inherent in social media, including ‘sexting’. Although the board has engaged with young people well, engagement with the wider community is less well embedded. Some work has been undertaken, for example encouraging mosques to nominate safeguarding leads and to provide safeguarding training. The board recognises the need to engage more with the wider community.
144. Up-to-date, relevant and well-written safeguarding policies and procedures are jointly commissioned with neighbouring boards in West Yorkshire. They are easily accessible to professionals and the public. Joint commissioning promotes consistency, which is particularly helpful for agencies that work across local authority boundaries. Procedures take account of local issues, such as the neglect strategy and toolkit, the ‘burns, bruises and scalds in non-mobile children’ protocol and guidance

for people who work with children in madrasas. Work is at an advanced stage of development to improve the board's website further, which will increase its accessibility and scope.

145. There is detailed and careful oversight of all child deaths that occur in the local authority. The child death overview panel brings together learning from all child deaths to inform future activities, such as safe sleeping campaigns. The annual report is clear and detailed.
146. Private fostering arrangements are reported to the board. The most recent annual report identifies strengths and weaknesses of current arrangements and sets out appropriate improvement actions.
147. The board is appropriately appraised of the work being undertaken by the designated officer, and this assures members that allegations against those who work with children are being properly investigated. The board receives sufficiently detailed annual reports from the designated officer.

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.

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