Coventry City Council

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

and

Review of the effectiveness of the local safeguarding children board[1]

Inspection date: 28 January–5 February 2014

The overall judgement is **inadequate**

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

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

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

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

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

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

Contents

Section 1: The Local Authority

Summary of key findings

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

1. Too many children and young people in Coventry who need help and protection are not seen swiftly enough or provided with a timely assessment of their needs, which means that they are left at risk of harm.

2. Leaders and managers have not tackled key weaknesses in children's social care quickly enough to ensure that children and young people are effectively helped and protected. Concerns about the capacity of the service to manage the volume of work in children's social care have been known for some time and were highlighted in the Local Government Association (LGA) review of children's services in March 2013.

3. Social workers in the referral and assessment teams have very high caseloads, and this means that they cannot do their job properly. The lack of robust management oversight of social workers' caseloads means that managers do not know whether all children have been seen or assessed. Social workers do not always receive the right level of supervision from their managers to enable them to discuss cases fully and make the right decisions for children and young people, to improve their outcomes and ensure their safety and welfare.

4. Domestic abuse notifications were not all jointly screened between social care and the police at the time of the inspection to ensure that there was timely sharing of information to assess risk for children.

5. When child protection concerns are identified, the arrangements for the management of child protection strategy discussions or meetings to discuss these concerns are not always effective enough. The police do not routinely attend all child protection discussions or strategy meetings with social care managers. In too many cases, there are delays in convening and recording the outcomes of these meetings, leaving some children for too long before the right decisions are taken to protect them. The local authority is aware of this and is currently reviewing these arrangements with the police.

6. A significant rise in the number of children requiring a child protection conference has resulted in the Independent Reviewing Service being unable to meet demand. Most initial child protection conferences are held more than 15 days after the strategy meeting decision to proceed to conference so, even when it has been agreed that children are at risk of harm, some children have to wait too long before there is a plan in place to protect them. Police do not attend all initial child protection conferences, nor do they always provide reports when these are required. All of these factors result in delays in information sharing and appropriate decision making to ensure that children are safe.

7. Too many assessments for children who need help and protection are not completed within appropriate timescales and they are not always of a good quality. Some assessments are not sufficiently child-focused, and they do not always consider all aspects of parental behaviour and the impact of this on children.

8. When children and families experience problems and need help, support is not always sufficiently targeted or coordinated. The early help and intervention strategy has recently been agreed but is not yet fully implemented. Not all partners are fully engaged in the early help offer; for example, health visitors undertake very few common assessments. Schools report that this results in many children entering education without their needs having been fully addressed, and this affects their learning. The lack of a coordinated early help offer has a significant impact on services as problems escalate, and this contributes to the increasing levels of referrals to children's social care.

9. Independent reviewing officers, who monitor plans for children who are looked after, have high caseloads. This means that they are not always able to track children's progress and intervene in their cases to promote care plans and review decisions to ensure that their outcomes are improving.

10. When children are placed for adoption, too many have not undertaken essential life story work to help them understand the reasons for adoption.

11. The number of private fostering arrangements known to the local authority is very low, and carers' assessments are not always completed promptly.

12. Not all children who go missing from home and education receive a return interview to ensure that they have the support they need to keep them safe.

13. When young people plan to leave the care of the Local Authority, their pathway plans are not always of good enough quality, as they do not analyse young people's aspirations well enough with regards to long term goals and employment. This reduces the effectiveness of the advice and support they receive.

14. Not all looked after children receive regular dental check-ups, and there is no system for monitoring whether all young people who leave care have their full health histories in place.

15. Information that tells leaders, managers and social workers how they are performing and what they need to do better is not always reliable, and this means they can't always be clear about the number of children who receive social work visits or if they get their meetings on time.

The local authority has the following strengths

16. The current Director of Children's Services, who was appointed in September 2013, is now driving actions forward to strengthen the service, with the full

support of the Chief Executive and the local authority and there is clear evidence of decisive action now being taken to address areas of concern. Significant funding has recently been agreed for 26 additional posts within children's services to address the workload issues, although this investment has not yet had a full impact as not all staff are yet in post. In addition, substantial funding has been agreed to provide a range of new services for children and families experiencing domestic abuse, which includes a single point of access to services.

17. The Local Authority has recognised that too many children have suffered long term neglect without the right action being taken. Targeted work to address neglect and emotional abuse with children under the age of four has resulted in an appropriate increase in the number of children who are becoming looked after.

18. The recently established Children and Family First teams, the increased number of CAF (common assessment framework) coordinators and close liaison with schools have led to an improvement in the numbers of CAFs being undertaken, so that many more families can now access the help they need early enough to prevent problems escalating.

19. When it is agreed that children or young people need a child protection plan to help keep them safe, a wide range of services are available for children and their families, and in many cases these interventions lead to improved outcomes.

20. Arrangements to support children on the edge of care have been strengthened. Good use is made of family group conferences when care options are being considered for children and young people. Planning for permanency for children at an early stage is improving, with good evidence that a range of options are increasingly used well to ensure that children secure permanent placements early. The use of specialist long-term residential placements has led to some good outcomes for children and young people. The percentage of children placed in families is good, with many children placed together with their brothers and sisters.

21. Looked after children make good progress in their education in some key areas, and when they need alternative provision this is readily available, of good quality and children receive their full entitlement to 25 hours provision per week.

22. Care leavers receive good support from the newly established Route 21 service. Social workers and personal advisors now work together in teams and have good access to information from different partners and services, which they use to meet the individual needs of young people. Provision and opportunities for care leavers have improved over the last three years and a very large majority of young people progress to education or training at the end of Year 11.

What does the local authority need to improve?

Priority and immediate action

23. Senior leaders and managers need to ensure that when children and young people are referred to children's social care they are seen and assessed swiftly, so that their safety is secured.

24. Senior leaders and managers need to tackle robustly the key weaknesses identified in the fundamental service review and the peer review to drive improvements in practice.

25. The Local Authority and partners need to ensure that early help is coordinated and effectively targeted through the implementation of the early help strategy, so that families receive support when need is first identified, and the number of referrals to children's social care is reduced.

26. Senior leaders and managers need to ensure that there is robust management oversight of social workers' caseloads, so that children and families receive the help and protection they need. Social workers' and Independent Reviewing Officers' caseloads should be manageable, so that they can undertake their work effectively.

27. The arrangements for child protection strategy meetings and discussions need to be reviewed to ensure that, as a minimum, a local authority social worker, their manager, a health professional and a police representative are involved, so that all relevant information can be shared and recorded effectively to assess risk for children.

28. Strategy discussions, child protection enquiries and assessments should be completed and recorded in a timely way to ensure that information is effectively shared, children are seen and risks assessed, and that children receive the right help and protection they need.

29. Promote police attendance at initial child protection conferences to ensure that all relevant information can be shared and considered so that the right actions are taken to ensure children's safety.

30. Assessments for children and young people should be child-focused and provide a thorough assessment of parental problems the impact of these on children, and a thorough analysis of all risk factors, to inform planning.

31. All plans for children and young people should be focused on their assessed needs, with clear outcomes and timescales by which progress can be measured.

32. Assessments in cases of private fostering arrangements should be completed within timescales.

Areas for improvement

33. Ensure that social workers have the quality time they need to spend with children, so that they can get to know them well and they can fully understand their needs and promote their welfare.

34. When a decision has been made that children will not be returning home, ensure that life story work is undertaken promptly, so that children can understand the reasons for this decision and be well prepared for their future.

35. Ensure looked after children receive regular dental health check-ups and that all young people leaving care have full information about their health histories in the form of health passports.

36. Independent Reviewing Officers should have regular contact with looked after children, so that they know and understand their wishes and feelings and can then robustly challenge all agencies involved to ensure that children's needs are met.

37. Children and young people who go missing should always receive a return interview so that professionals understand why they went missing and what steps can be taken to ensure that this does not happen again.

38. Improve the quality of pathway planning so that the aspirations of young people are clear and long-term plans for their education and employment are identified at an early stage to ensure young people receive the support they need.

39. Care leavers should be fully informed of their rights and entitlements when they leave the care of the local authority.

40. The timeliness of adoption and permanency placements should continue to improve to bring this performance in line with national targets.

41. Ensure that there are sufficient adoptive and foster placements to meet the specific needs of children for appropriate permanent placements.

42. Develop the workforce strategy to attract and retain skilled and experienced permanent staff in Coventry, and ensure all staff receive regular supervision that provides the opportunity for challenge, reflection and professional development.

43. Ensure that findings from audits, together with reliable performance reporting, are driving improvements to promote high standards of professional practice so that children are safe.

Information about this inspection

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

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

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

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

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

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

The inspection team

Lead inspector: Wendy Ghaffar

Team inspectors: Sean Tarpey, Deborah Barazetti-Scott, Gary Lamb, Dick O'Brien, Jansy Kelly, Kenneth Jones, Nancy Meehan, Stephanie Murray.

Information about this local authority area[2]

Children living in this area

- There are currently approximately 70,500 children and young people in Coventry aged between 0-17 years old out of a total population of 316,900 (22%). This includes 13,900 children under three years old. (Source: mid 2011 Census based population estimates, Office for National Statistics)

- 20% of school-age children are eligible for a free school meal. For children attending primary, secondary and special schools this breaks down as follows (source: Jan 2013 School Census):

  - in primary schools 21% of pupils (this includes children in nurseries) (the national average is 18%)
  - in secondary schools 18% of pupils (the national average is 15%)
  - in special schools 41% of pupils (the national average is 37%).

- Children and young people from minority ethnic groups account for approximately 39% of all children living in the area, compared with 26% in the country as a whole (Census 2011).

- The largest minority ethnic group of children and young people in the Borough are Asian/Asian British at 18.1% (Census 2011)

- There are over 100 languages spoken in Coventry. The proportion of children and young people with English as an additional language is as follows (source: Jan 2013 School Census):
  - in primary schools it is 28.7% (the national average is 18%).
  - in secondary schools it is 25.1% (the national average is 14%)
  - in special schools it is 19.2%.

Child protection in this area

- At 31 December 2013, 4,330 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 3,085 at 31 March 2013.

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

- At 31 December 2013, 657 children and young people were the subject of a child protection plan. This is an increase from 519 at 31 March 2013.
- At 31 March 2013, four children lived in a privately arranged fostering placement. This is an increase from two children at 31 March 2012.

Children looked after in this area

- At 31 December 2013, 633 children are being looked after by the local authority (a rate of 88.9 per 10,000 children). This is an increase from 619 (86.9 per 10,000 children) at 31 March 2013.
- Of the 633 children looked after at 31 December 2013:
  - 332 (52.4%) were placed out of City
  - 4 (0.6%) were unaccompanied asylum seeking children
  - 83 (13.1%) were placed in residential children's homes, of whom 42 (50.6%) were out of City
  - 6 (0.9%) were placed in residential schools, all of whom were out of City
  - 455 (71.9%%) were placed in foster care, of whom 235 (51.6%) were out of City, with 197 of these less than 20 miles from home; 38 local children (8.3%) were placed in foster care more than 20 miles from home
  - a small number of children (26) were placed with parents
  - the remaining 63 children were in various types of placement including adoptive placements and independent living.
- In the 12 months to 31 March 2013:
  - there were 40 adoption orders
  - 21 children became the subject of special guardianship orders
  - 257 children ceased to be looked after, of whom 21 (8.1%) subsequently returned to being looked after
  - 20 young people who ceased to be looked after moved on to independent living.

Other Ofsted inspections

- The Local Authority operates two children's homes. These were both judged to be good in their most recent Ofsted inspection.

- The previous inspection of Coventry Children's Services for safeguarding and looked after children was in March 2011. The Local Authority was judged to be good for safeguarding, adequate for looked after children's services and good for overall effectiveness.
- The Local Authority's fostering service was judged to be good in the most recent Ofsted inspection, and adoption services were judged to be adequate in their most recent Ofsted inspection.

Other information about this area

- In September 2013 Coventry City Council established the People Directorate, which brought together the former Community Services and Children Learning and Young People Directorates. The role of Executive Director of People was introduced, which takes on the responsibility of the Director of Children's Services and Director of Adult Services. The current Director was appointed to this post in September 2013.
- The Chair of the LSCB has been in post since September 2011.

Inspection judgements about the local authority

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

44. When children and families need help from early support agencies, these services are not always well targeted and coordinated, and this means that children and families may not receive help that is appropriate for their specific needs, nor early enough to prevent problems escalating. A Prevention and Early Intervention Strategy has been agreed, but is not yet fully implemented, and not all partners are fully engaged in early intervention and prevention work. However, the local authority and partners have invested in prevention and early intervention services with some evidence of impact. The Parenting Service provides 'Triple P' parenting courses at universal, targeted, and specialist levels, and parents report good outcomes from this support, with improvements in their children's behaviour. Children's centres provide groups to support parents whose children are looked after, and a range of family support services.

45. When concerns increase about families and they need social care help, the Early Help Hub works well in supporting agencies to be clear about how and when to refer families into social care. A Common Assessment Framework (CAF) coordinator is based in the early help hub and ensures a prompt response to families who are referred for an early help assessment. The recent establishment of the Children and Family First teams and the increase in the number of CAF coordinators, together with improved links with schools, have resulted in an increased offer of early help. The number of CAFs is increasing and these assessments and offers of help are particularly well embedded in schools. There are some good examples of improved outcomes as a result of this work, particularly in improvements in school attendance rates for some young people.

46. School staff reported to inspectors that learning from a recent serious case review has resulted in improvements in communication with the referral and assessment service, including feedback from children's social care when a referral had been made. However, despite targeted training for health professionals, the numbers of CAF's undertaken by health staff remains extremely low. This means that services for children under the age of two are not always well coordinated to improve outcomes. Some schools report that children enter school without their needs having being addressed at the pre-school stage, and this affects their learning.

47. The local authority has recognised the need for early help services to respond to identified need, such as 0-2 year olds, and has begun to reshape services to meet these needs. For example, a pilot project in two children's centres to bring together health visitors, midwives and GPs is beginning to have an impact in providing continuity of care for some of the most vulnerable families. However, this service is not available across the city and, overall, partner agencies are not

getting involved with families quickly enough to prevent problems from becoming worse.

48. Partner agencies clearly understand the threshold for referral to children's social care and thresholds are appropriate. Where thresholds for social care services are met, there is effective management decision making at the point of referral, and clear management direction to identify action needed; these cases are forwarded appropriately to the referral and assessment team for social care intervention. However, children are not always seen quickly enough, and their need for help and protection is not always assessed promptly, and this means that too many are left at risk of harm.

49. Information sharing between agencies at key stages in the child's journey is inadequate. Delays in the recording of significant information, such as strategy meetings and child protection enquiries, mean that up-to-date information is not always readily available to professionals when determining risks to children.

50. When families are identified where domestic abuse has taken place, information sharing between agencies to identify risks and protect children is not sufficiently robust. During the inspection, cases were identified where there were delays in children's social care receiving information on domestic abuse notifications, following screening by the police. In a small number of these cases, this resulted in delays of several weeks before incidents were reviewed by a social worker. This was a key issue highlighted in the most recent Serious Case Review published by Coventry, and it is still not resolved. The process of joint screening of medium and high risk domestic abuse notifications at a weekly meeting attended by the police, children's social care and health, has serious weaknesses. Health professionals do not receive sufficient notice of cases to be discussed, and are therefore unable to bring relevant information about the family to inform the assessment of risk. Problems in the screening of domestic abuse notifications has been acknowledged by partner agencies and known for some time, and a new system of joint screening of all notifications was introduced whilst the inspection was on going, but the impact of this was not seen. This is an interim measure prior to the establishment of the Multi-Agency Safeguarding Hub (MASH) planned for the summer of 2014.

51. When children are identified as being at risk of harm, strategy meetings are arranged, but the police do not routinely attend these meetings. Police only attend strategy meetings in the most high risk and complex cases. In most other circumstances, an email is sent to the police referral unit requesting a strategy discussion. If the police respond in time, a strategy discussion with children's social care is held and the details from the discussion will inform the subsequent strategy meeting. However, there are numerous occasions when the police do not respond in time and this means that there is no strategy discussion with the police and therefore necessary information is not always available to inform decision making at the strategy meeting. Currently, partners do not work together robustly enough to ensure that children are adequately

protected. The local authority is aware of this and is currently reviewing these arrangements with the police.

52. In too many cases, delays were seen in holding and recording child protection strategy discussions and meetings, and inspectors could not find records of meetings held on some children's files. Concerns about the recording of strategy minutes were identified in the action plan for a recent Serious Case Review on the death of a child and referred to in the recent update of the progress of the plan, yet these issues have still not been rectified.

53. When child protection investigations are undertaken, they are conducted by suitably qualified and experienced social workers; and when joint work is undertaken with the police, child protection enquiries are effective. However, the outcomes of these investigations are not always routinely recorded in a timely manner, so that all key information about a child is available and up to date on the child's file. This has serious repercussions when, for example, the out-of-hours service has to deal with a crisis involving a child who is known to social care, and they do not have the full information available to fully assess the risks.

54. Assessments for children who need help and protection are not always completed in timescales and this has resulted in some children not receiving the help they need quickly enough. The delays in commencing and completing assessments are attributed to the very high caseloads of social workers in the referral and assessment teams, some of whom have caseloads where they have responsibility for 60 children. A lack of robust management oversight of these cases has meant that managers cannot be assured that all children have been seen and their risks assessed.

55. There has been a significant increase in the number of referrals to children's social care since March 2012. Throughout 2013, the rate of referrals was significantly higher than the national average. At 31 December 2013, 4,330 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 3,085 at 31 March 2013. Between March 2012 and November 2013, there was a 20% increase in the number of children and young people made subject to child protection plans. Senior and middle managers are fully aware of the difficulties and the impact on practice due to this increase in activity, but have been slow to respond. Managers report that it is difficult to close down work as new work is prioritised, and supervision notes indicated that managers were stressed and feeling under considerable pressure. As an interim measure, to address the capacity issues in the referral and assessment team, additional agency staff have been recruited. However, these measures have not been sufficient to meet demand or to ensure that all children are seen quickly enough. An additional team has now been created in the referral and assessment team, but this only became operational on 3 February 2014. Funding for additional posts in the neighbourhood teams has also been agreed, but permanent staff have not yet been appointed.

56. As a result of the volume of work, some children in need cases in the neighbourhood teams are not allocated specifically to social workers, although they are overseen by managers. Tasks are progressed through duty arrangements within teams. This means that some children and families do not receive a consistent service from an allocated social worker, and children and families do not have the opportunity to develop stable working relationships with social workers. Such pressures are reported by managers and social workers to have been compounded by the consolidation of business support services. Most operational staff report that they are now completing tasks which they previously considered administrative.

57. The quality of assessments vary from poor to good. While the signs of safety model is widely used, the analysis of risk is not always sufficiently thorough and child focused in all assessments. Assessments of complex cases that include domestic abuse, parental substance misuse and mental health do not always analyse all aspects of parental behaviours in terms of their impact on children.

58. Some children receive good assessments, and in these cases chronologies are used well to consider historical context and risk factors. The voice of the child was evident in many, although not all, assessments, with some examples of very good consideration of ethnicity, culture and language, and effective use of interpreters to ensure that the views of children are sought. In addition, the behaviour and interaction of young children with their parents was analysed well in some cases.

59. When it is identified that children's needs should be considered at a child protection conference, there is often a significant delay before meetings are held. Data indicates that 60% of conferences are held later than 15 days after the strategy meeting has agreed that the case should go to conference. This means that there is a lost opportunity to ensure that all information is effectively shared in a timely manner, with measures put in place swiftly to reduce risk to children. In some cases, the lack of attendance or submission of reports from police at initial child protection conferences means that the full range of risks to children is not known; this could result in poor decision making, and potentially leaves children at higher risk of significant harm. The police are currently reviewing attendance issues. Minutes of meetings from child protection conferences currently take more than two weeks, and often much longer, to be distributed to professionals. Performance on the timeliness of review conferences is much better, and nearly all review conferences are held in time.

60. Parents are encouraged and enabled to contribute their views during child protection conferences, and they report that the use of the signs of safety model helps them to understand what they need to do to keep their children safe. Case conferences observed during the inspection were well managed, with a sensitive approach to the engagement of parents. Children are not routinely engaged in child protection conferences, although independent advocacy services are available for children, and the system for accessing this is

well used. The advocacy service gathers children's views before conferences to ensure that their voices are heard.

61. There is no routine formal feedback to managers and senior managers from child protection chairs about the quality of reports and progress of plans, and this is a lost opportunity to identify trends and promote good practice.

62. When children need a plan to help support them, many of these plans are effective in identifying and meeting children's needs. However, in some cases plans seen do not reflect children's needs, and timescales are not clearly identified to enable professionals, parents and children to know what actions should be taken and when they should be completed, so that children's circumstances improve. In most cases, core groups are regularly held and well attended by professionals, and many provide effective monitoring of the progress of plans.

63. When children are subject to child in need and child protection plans, a wide range of services are available to help support them. The Intensive Case Support Panel is well attended by a range of agencies and is effective in promoting the progress of plans by ensuring that children and their families receive the right support and services. In cases reviewed by inspectors, many examples were seen of these interventions resulting in good outcomes for children. For example, children and young people were supported to understand how to keep safe and work through their experiences of abuse; how to develop their sense of self-esteem and build more positive relationships with family and friends; and how to improve attendance at school and reduce antisocial behaviour. Services include the NSPCC working with neglect, Compass drug and alcohol treatment for under 17's, the Young Carers service, the Multi Systemic Therapy team, the Barnardo's Defuze project that supports children who have experienced domestic abuse, and a specialist counselling service for girls and young women who have experienced sexual abuse.

64. When families no longer need help from social care, there is a good process to signpost them to other services. The Troubled Families programme has good links with housing services, police, the youth offending service and probation, so that those in need of intensive support are easily identified. The service has identified 83% of the 905 troubled families initially targeted by government, and has had some good success in helping families into work and preventing children entering care. The team has been recognised by the Department for Communities and Local Government as evidencing best practice in identifying, tracking and working well with families.

65. When children and families are identified as high risk victims of domestic abuse and referred through to a multi agency assessment conference (MARAC), good information sharing and timely action means that these families receive an appropriate service to help reduce risks to them. These meetings reflect a clear understanding of the dangers posed to children living in circumstances of domestic abuse and actions that need to be taken by partners to reduce risks to

ensure their safety. The thresholds for referral to these meetings are clear, but the large majority of referrals are from the police, suggesting that more work needs to be done to ensure all of those working with children know the criteria for a case to be discussed at a MARAC.

66. The number of children known by the local authority to be subject to private fostering arrangements is extremely low. Of those who are known to the service, carer assessments are not always completed in timescales that meet minimum statutory requirements, which means that childrens' safety and well-being is not always assessed in a timely manner.

67. In cases seen by inspectors children who go missing from home and school and/or who are at risk from Child Sexual Exploitation (CSE) benefit from a coordinated multi-agency response and they are linked with appropriate support and preventative services to assist them in understanding risk and keeping themselves safe. Systems are in place to track children who are at risk of CSE through the multi-agency screening panel (MASP). However, not all children and young people who have been missing from home or from education are able to reflect upon their missing episode with an independent person and identify potential risks through a return interview, particularly those young people of secondary school age who should receive this input from the youth service. This represents a missed opportunity to identify trends and provide support through early help.

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

68. Once children enter the care of the local authority, the level of service they receive is better than the experiences of children who need help and protection. However, the demand for the service is high and the number of looked after children continues to rise; in March 2013 it was 619, which is 87 per 10,000 children, compared with the England average of 60 per 10,000. The service is over stretched in key areas, and independent reviewing officer caseloads are high. Social worker caseloads are more manageable in the Neighbourhood and Looked after Children teams than in the Referral and Assessment teams, but their work is complex and they are also required to undertake duty tasks in their own teams. As a result of this, some work and plans are not good enough to ensure that children's needs are comprehensively met. However, there are examples of good, effective work with children, leading to improved outcomes, with the best work completed in cases where there are few changes in the allocated worker.

69. A range of factors are leading to high numbers of children becoming looked after, including changes in demographics, increased birth rates in some of the most deprived communities, high levels of domestic abuse and substance misuse and a legacy of un-met need, particularly relating to the long-term neglect of some children. These issues have been recognised by the local authority, and targeted work to address neglect and emotional abuse with children under four years of age has resulted in an appropriate increase in the number of children who are becoming looked after. The threshold for access to the looked after children service is set at the right level. Inspectors found no cases of children made subject to the care system inappropriately.

70. Arrangements to support children on the edge of care have been strengthened. Step-up procedures and practice to support planning for children is increasingly effective, including the use of the 'Access to Resource' panel and 'LAC tracking' system to ensure children are getting the help they need, and to make sure that the right decisions are being taken to avoid children being left in unsafe situations. Effective use is made of parallel planning and twin tracking of cases. Step down arrangements from care work well. Special Guardianship Orders have been used in 53 cases in the last year to successfully divert children from being looked after, 29 of these were for children in long-term care. Children who return home are well supported, with good use of family group conferences, and plans and services that are appropriate and ensure continuing support for children and their families. The proportion of children who have left care and were re-admitted is low at 16 (6%) between April and December 2013.

71. When children need to be in care, good use is made of the Public Law Outline. Effective partnership work between Cafcass, guardians and the courts, in family justice meetings, helps to support appropriate and timely action to plan permanence for children. Social workers and their managers have access to

good quality legal advice and training. Letters before proceedings are used well and are followed by effective pre-proceeding meetings which involve parents, so that they are clear about local authority concerns and the actions that are being taken to protect their children.

72. The quality of assessments for looked after children is variable. Many assessments are good and are sharply focused on reducing risks; they include clear analysis and make good use of research and risk assessment techniques. The courts are increasingly confident in the quality of in-house social work parenting assessments and this has reduced the need for independent social work assessments, which had previously contributed to delays in decision making. There has been a real effort to improve the voice of the child in assessments, which is demonstrated well in the most recent assessments seen. A small number of assessments are not completed in time, leading to delays in the development of plans for some children. A small minority of assessments do not contain sufficient analysis of risk and protective factors. Chronologies are nearly always in place, but these do not consistently provide a good overview of children's circumstances.

73. All looked after children are allocated to a qualified social worker, although children and young people report that their social worker does not spend enough time with them when they visit. Only 82% of looked after children see their social worker at the required frequency. Nearly all the looked after children's cases are complex and challenging, requiring significant input from workers to improve outcomes for children. Many social workers have to spend one day a week on duty within their own teams, and this results in them constantly prioritising and re-prioritising their workload, so their response to children's needs is not always timely. In the most recent work seen by inspectors, there are examples of social workers visiting children more frequently to progress care plans.

74. The quality of care plans is too variable because they do not always include measurable outcomes and clear timescales; and a very small minority of children (9%) do not have an up-to-date care plan. The vast majority of care plans ensure that children are encouraged, where appropriate, to keep in contact with families. Issues of diversity including ethnicity, culture and religion are routinely considered in care plans, for example, ensuring the involvement of parents in selecting an appropriate place of worship near to a child's placement. The recently implemented care planning, placement and case review regulations that govern young people received into custody have been implemented effectively. Only one young person is placed in bed and breakfast provision, and an appropriate placement has now been offered.

75. The right permanence options are being identified for most children. A wide range of options are explored and used to achieve permanence for children, including specialist long-term residential placements out of City. Two of these cases were tracked for this inspection and there is clear evidence that the placements are making a positive, demonstrable difference for those children. A

number of additional cases were also sampled of children and young people who are placed out of the City and these cases demonstrated effective work, including consistent, focussed care planning and regular visits to children. The number of looked after children placed with families is good. Of the 625 looked after children in Coventry, 432 are in foster care placements, and 84% are placed with families. Appropriate consideration is given to ensuring that children are placed with their siblings, and 63% of children are placed with their brother or sister. Performance on short-term placement stability is good. The rate of children living more than 20 miles from the community where they live is low at 12% (77).

76. The cultural and religious needs of children are considered well when placement decisions are made. This ensures that foster carers and other providers can meet the specific cultural and religious needs of children. Other examples include ensuring that young people have appropriate support to explore issues of gender identity.

77. However, insufficient priority has been given to the retention, training and support of foster carers. Placement sufficiency with in-house foster carers is a significant challenge for the local authority. The strategy for the recruitment of in-house foster carers has not been effective and numbers continue to decline, which is resulting in the high use of Independent Fostering Agencies (IFAs) at additional cost to the authority. Plans to increase the number of in-house foster carers are well developed, but as yet there is little evidence of impact.

78. The two local authority children's homes were judged good by Ofsted in their last inspections. There is a clear policy to place children in good or better provision and action is taken to ensure children live in safe places. The local authority takes appropriate action to respond to Ofsted inspection judgements when services are not judged good.

79. Arrangements to ensure that looked after children's health needs are met are improving from a low base. The proportion of looked after children who receive an initial health assessment within 15 days of notification has improved to 84%, and 87% of annual health assessment reviews have been completed this year to date (December 2013). However, the latest management performance information shows that only 55% of children have received a regular dental health check in the last year, which is very poor performance.

80. There are many examples of effective social work interventions leading to improved outcomes for children. For example, therapeutic interventions such as CAMHS and the 'Journeys' service help to support children with complex needs, which is making a demonstrable positive difference to their well-being. There has been a steady reduction in the number of looked after young people who have been convicted of an offence for the first time in the year ending December 2013, with the number very low at only 12 young people.

81. Looked after children make good progress in their education in some key areas. Attendance rates for looked after children are good at 94%. There have been no recent permanent exclusions of looked after children, and fixed term exclusions have reduced and are below the national average. Pupils make better progress between Key Stage 2 and Key Stage 4 than the national average for looked after children. Attainment for looked after children at Key Stage 4 shows steady improvement over three years. Good alternative provision is provided at Key Stage 3, and four Pupil Referral Units (PRUs) ensure that young people receive 25 hours provision a week.

82. There is no specific policy on placing children in good or better schools. Almost a third of looked after children and young people attend schools which require improvement or are inadequate. Personal Education Plans (PEPs) are not always sufficiently detailed to ensure that all academic targets are clear to consistently support improvement in educational outcomes. Completion rates have improved recently, with 89% completed in 2013. There is effective tracking of pupils' progress in Coventry secondary schools by the Looked after Children's Education Service (LACES) team, with support and challenge promoting improvement.

83. Independent Reviewing Officers (IROs) have high caseloads which are considerably higher (110–120) than those recommended in the IRO Handbook (50–70). This affects the scope and depth of work undertaken to track and intervene in children's cases to promote care plans and review decisions to ensure that children are making good progress. IRO's have limited time to prepare children for their review and to explain how decisions affect them. Despite this, officers have effectively prioritised the support they give to children placed a long way from the Coventry area and 96% of children's statutory reviews are held on time, with IROs ensuring that children and young people's attendance at reviews is good at 86%. Reviews are well attended by all professionals and recent work demonstrates that a real effort is being made to ensure that children's views are represented. Carers report that they are involved in meetings, their views are taken into account and they receive copies of care plans, but they do not consistently receive a copy of the notes made at reviews.

84. Children and young people report that they know and understand how to complain and the system is well used by children and families. However, the large majority (78%) of complaint investigations are not dealt with within the ten day timescale. More compliments were received than complaints about the looked after children's service, Specialist and Youth Offending Services during April 2012 to March 2013.

85. Advocacy is offered to all children in care, including those who are placed outside the City. The Advocacy Service is well-established and has experienced staff, some of whom have British Sign Language (BSL) and Makaton skills, which ensures that children's voices are heard. The use of interpreters is well-embedded. An independent visiting service is available to all looked after

children but the take up rates are low, with only 23 children receiving a service. Young people who use the service report that they are very satisfied with the advocacy and independent visiting service, with 94-100% giving positive feedback in all the key areas.

86. Systems are in place to track and identify the children in care who go missing and those who are at risk of sexual exploitation. Where risks are identified, these are effectively considered through the Multi-Agency Screening Panel. In cases seen there is good joint work between staff in children's homes and the police and there are examples of appropriate support being identified and delivered to individual young people as part of their plan to reduce risk, including those placed a long way from Coventry.

87. The Children in Care Council ('Voices of Care Council') is a model of good practice and there are many examples of children and young people shaping and influencing services, leading to real change and improvements which have made a demonstrable difference to children's lives. Representatives from the Voices of Care Council identified that young people attending college could earn more than those undertaking apprenticeships. This was raised with elected members and additional payments for care leaver apprenticeships were agreed. Young people in the council were influential in the development of supported accommodation and took part in the tender evaluation for the project. Children and young people reported to inspectors that the CiCC has promoted their sense of belonging and helped raise their self-esteem. Practice is embedded and effective, with mature links between children and young people in care and elected members; children and young people told inspectors that they knew elected members well. A service pledge is in place which was written by children and young people, and they report that they know and understand their basic rights and expectations of the service they receive whilst they are in care. However, there were examples when children and young people felt they were not given an appropriate response to individual requests; these had been challenged by the CiCC, who received an immediate response from the corporate parenting panel that issues would be addressed. Good arrangements are in place to support the involvement of children and young people placed outside Coventry through the well-used, dedicated CiCC website.

The graded judgment for adoption performance is requires improvement

88. Some children who need to be adopted have waited too long for an adoptive placement. However, decisive and targeted action to address this has resulted in an increase in the number of children being placed for adoption and recent significant improvements in the time that this takes, although there remains a legacy of some children who are still not matched to an adoptive family. Managers have a clear understanding of the strengths and areas for development of the service, and progress has been made in addressing the areas identified in the adoption inspection in 2013.

89. During 2012–13, it took 821 days on average between a child entering care and moving in with their adoptive family, which is 213 days longer than the national target. Since then there has been a good improvement, with a reduction in the time taken for a child to be placed for adoption and this figure is forecast to reduce to 630 days by April 2014. This would be a significant narrowing of the gap between Coventry's performance and the national target, but remains an area where further improvement is needed, since the national target is now 547 days. Court processes affect this performance and outcomes of hearings are not yet being concluded within the recommended 26 weeks. The time taken by Coventry between receiving Court authority to place a child and the child being placed for adoption has improved very strongly, but still doesn't meet the national target of 152 days.

90. Many children benefit from long-term, stable placements with foster carers who know them well and provide consistently good links with potential adopters. These links help provide accurate information to inform good matching. Social workers mostly provide well-prepared documentation which helps to facilitate court processes. However, chronologies in child permanence reports are overly focussed on parents and don't always provide a comprehensive or clear picture of key events in children's lives. In addition, work with children to ensure that they understand as fully as possible the reasons why they are in care and why they are to be adopted, is not timely. As a result, children frequently enter adoption introductions without life story work being completed. Until recently, there have also been delays in arrangements with health services for adoption medicals for children, which has slowed down the process of planning for some children who need permanency. Arrangements for medicals are now appropriate and timely.

91. All adopters spoken to by inspectors commented on the very prompt and welcoming response to their initial enquiries about becoming an adopter. Essential checks, such as with the police and referees, are subject to well-embedded and suitable processes. All reports seen by inspectors regarding prospective adopters address issues from applicant's backgrounds, experience and values. The adoption service actively encourages, and has been successful in, the recruitment of adoptive parents from a wide range of backgrounds, including ethnicity and sexual orientation. Preparation groups are seen as helpful by adopters, who often recognise how the groups expand their knowledge of the challenges and meaning of adoption. The input of adopters at these groups is welcomed by all prospective adopters.

92. Almost all adopters are now being reviewed promptly at the Adoption Panel, and the Agency Decision Maker makes decisions speedily and thoroughly. A national six-month two-stage target for approving adopters was introduced in July 2013, but it is too early to measure how well this target is being met. Following a recent increase in enquiries, not all adoption applicants were able to access preparation groups promptly because of a lack of social work capacity. Currently, Coventry has 42 approved adopters not yet matched to children. There are 70 children with an adoption plan and not yet matched, of

whom 27 have robust plans in place with identified adopters. Coventry is making appropriate and timely referrals of adopters to the Adoption Register.

93. Matching of children to adopters follows a thorough process. Introductions are well organised and paced to meet the needs of the child. All adopters comment very positively on the accurate information they are provided with in documents and DVDs about the child as they are now. Medical advice during matching on children's health is now prompt and helpful.

94. In Coventry, it is the usual practice for the social worker who completed the adopter's assessment to transfer the adopters to a new social worker, who supports them when they have a placement. All adopters spoken to by inspectors criticised this practice, since it means that the adopters are still getting to know their new support social worker when they are entering the important stage of matching and introductions.

95. There have been 41 adoption placements in the year so far, a significant improvement on 2012–13, when 40 children were placed in the whole year. Coventry is ambitious and tenacious regarding the placement of brothers and sisters together and has performed well in this respect. The ethnic and cultural backgrounds of looked after children are well represented in the group of approved adopters and those in assessments. In many cases, children are appropriately matched for adoption with families who can meet their ethnic and cultural needs. Coventry provides a variety of forms of permanence, including adoption, Special Guardianship Orders and Fostering to Adopt. Fostering to Adopt is now established, with five children placed this year by this route, which is aimed at reducing avoidable changes of carers, particularly for very young children.

96. Adoption Support Plans are thorough. After-adoption support is provided to adopters through specialist workers with high levels of skills, such as in play therapy and Theraplay. There are currently 15 children receiving adoption support and none waiting for this service. The support includes a flexible variety of services through individual work, groups and workshops. Support to birth family members is provided by a commissioned service. The service has developed to meet individual needs, for example by linking birth parents to other parents who have had similar experiences, to provide more support; and the service is well used by birth families.

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

97. Care leavers are well supported through the new Route 21 service which was established last year. However, while the very large majority (85%) of care leavers now have a pathway plan, and targeted work is underway to ensure all young people have a plan, their quality is too variable. Plans identify the immediate needs of young people, and this ensures that they receive the support and health care they need. Social workers and personal advisors (PA's)

know their young people well. However, plans do not analyse young people's aspirations well enough with regard to long-term goals and employment, and this reduces the effectiveness of the advice and support they receive.

98. There is no annual programme of events to help young people plan for independence which social workers and Personal Advisors could draw upon to support pathway planning, and to which young people could contribute. Young people who spoke to inspectors felt that they were safe where they live. There is, however, no systematic approach to reviewing risk and local intelligence to ensure locations are safe when care leavers take up tenancies.

99. Social workers and personal advisors now work together in teams and have good access to information from different partners and services, which they use to address the individual needs of young people. Regular contact with young people is forging purposeful relationships, and the arrangements are beginning to overcome concerns previously voiced by care leavers that they have to spend time getting to know new people on their journey to independence.

100. The proportion of care leavers who are not in education, training or employment has reduced well (from 51% in 2010–11) to 34% in 2012–13, which is now below the national average (36%); the very large majority of young people progress to education or training at the end of Year 11. The Looked after Children's Education Service (LACES) team has started to work more closely with Route 21, to improve planning for progression post-16 and to track young people's progress. Care leavers living outside the City do not benefit to the same extent from the support and challenge provided by the LACES team to city schools, colleges and other providers, as the team does not have the capacity to undertake visits to schools out of authority. However, up-to-date attendance information about the progress of young people placed out of the City is provided through Welfare Call, and this information is used as an indicator of concern, with appropriate action taken when required.

101. Provision and opportunities for care leavers have improved over the last three years and are now good, as indicated by the very large majority of young people progressing to education or training at the end of Year 11 and reducing NEET levels. Taster opportunities in a range of vocational areas and an access to apprenticeships programme help young people to develop their employability skills, confidence and motivation. Around 10% of apprenticeships offered by the local authority are taken up by care leavers.

102. Young people are encouraged to progress to higher education, helped with transport and accommodation and paid a bursary. Good partnership work is currently undertaken by Warwick University and the local authority to support 40 looked after young people to raise their aspirations and expectations to progress to higher education. There are currently 15 young people at university in receipt of financial support from the council, some of whom are studying for masters degrees.

103. The local authority celebrates care leavers' successes and listens to their views through the Voices of Care Council, and acts on their recommendations; for example, in developing options for supported accommodation. Social workers and personal advisers do not, however, always ensure that care leavers know about all of their rights when they leave care.

104. When care leavers suffer from emotional health concerns, or drug and alcohol issues, they are provided with prompt access to commissioned health services. However, not enough attention is given to ensure young people attend appointments, engage with services and take responsibility for their behaviour. While the Looked after Children nurse offers young people leaving care the opportunity to discuss their health histories and to receive a written copy of this, there is no monitoring of how many young people take up this offer and no system of health passports for all young people leaving care.

105. Care leavers have access to a good range of recently commissioned supported accommodation options and are encouraged to stay with their foster carers. The City is in the process of agreeing a 'Staying Put' policy. Around 27 care leavers have benefitted from this arrangement annually for the last two years. Care leavers have priority for social housing, and tenancies for those who can live independently are secured within three months of their 18th birthday.

Leadership, management and governance are inadequate

106. Leaders and managers have not yet sufficiently tackled the weaknesses in children's social care which have been known for some time, to ensure that children and young people are effectively safeguarded. While the local authority can articulate the strengths and weaknesses of the service as identified in their recent self-assessment, including the actions that need to be taken to tackle these weaknesses, actions have been too slow and too many children remain at risk of harm.

107. The authority undertook a fundamental service review in 2012, but some key goals of the review, to reduce the number of looked after children and increase the sufficiency of in-house foster care provision, and thereby capture associated savings, have not been met. The number of looked after children has continued to increase and the provision of in-house foster carers is not sufficient, with an over-reliance on Independent Fostering Agencies at a significant cost to the authority.

108. The Local Government Association (LGA) review of children's services which was commissioned by the local authority in March 2013, found that the increasing rate of referrals, child protection concerns, and rising number of looked after children, indicated a service overstretched in terms of capacity and financial resources, and the situation was unsustainable. This review led to an action plan to tackle the identified weaknesses, but the response from leaders and managers was insufficiently robust and has not led to significant improvement in the quality of services for children and young people.

109. Since the LGA review in March 2013, rates of referrals have remained very high and there has been an increase in the number of children subject to child protection plans. A range of factors have combined to cause increased activity across children's social care and a high demand for services. A recent serious case review attracted national and local media attention, and has resulted in heightened public and professional awareness of issues of abuse and an increased number of referrals into children's social care. Reported domestic abuse rates in Coventry are the highest in the West Midlands and there is a significant peak in births in the two most deprived wards in the city. While leaders and managers have been aware of these issues, they are only now starting to take proactive measures to address these concerns.

110. Management oversight of cases, including scrutiny by senior managers, is not sufficiently well embedded and systematic, and this means that case work is not being driven so that children receive the help and protection they need at the right time. The quality and frequency of social work supervision is too variable. Supervision does not routinely occur in accordance with the local authority's own policy; it is too task orientated and is not sufficiently reflective. This inhibits learning and opportunities for positive challenge. Newly qualified social workers do not always have a protected caseload.

111. Social work managers make use of a dashboard which provides information to enable them to monitor performance on a daily basis, and a leadership dashboard to provide up-to-date data on a range of indicators, such as the numbers of child protection plans and number of care leavers. However, it is reliant on the inputting of data into the authority's integrated children's system by operational staff, which does not work well in all areas as some staff have too little time to input information in a timely and efficient manner. As a result, not all areas of the data are reliable, and some management reports cannot be collated effectively. This affects the ability of managers to comprehensively use performance information to drive improvements in practice.

112. Performance management information is collated across a wide range of activity and reported on a monthly basis to the Children's Social Care and Early Intervention Performance Board, which the Chief Executive and Lead Member regularly attend. Performance has improved in some areas as a result of this oversight, for example improved tracking of children who are voluntarily accommodated under Section 20 of the Children Act 1989, where children are in care for more than three months.

113. The current Director of Children's Service, who was appointed in September 2013, and his new senior management team are now driving actions forward to strengthen the service, and this is underpinned by a good internal self-assessment and a Children's Services Improvement Plan. As a result of this, the Director has secured significant investment in additional staffing to deal with the influx of work. New posts have been created, with the establishment of six additional permanent social work posts and 12 temporary posts for up to 18 months. Currently, 15% of the workforce is agency staff, but this is expected to reduce as permanent staff are appointed. Funding for an additional permanent manager and temporary manager has also been sourced. Such appointments have assisted in the creation of a further team to work within the referral and assessment service to ease pressure by creating a five-week duty cycle. As this team only went live on 3 February 2014, the impact of the new investment is yet to be seen. In addition, funding for a team manager and six IROs has been agreed. In recognition of the high rates of domestic abuse the council has also agreed an additional £250,000 for the development of domestic abuse services.

114. The new senior management team has effectively tackled some areas of poor practice, including the capability of a small minority of managers, and a review of the suitability of all foster carers has resulted in some leaving the service. Targeted work has been undertaken to address historic drift and delay in cases of neglect and emotional abuse, which has appropriately resulted in more children becoming looked after.

115. In recognition of the need to improve early support to children under two years old, piloted work is in place in two children's centres to identify and provide early help to the most vulnerable mothers of new-born babies. However, the local authority recognises the need for its partners to be better engaged in

early help if this is to be fully effective in reducing demands on child protection services, and this is a significant challenge for the partnership to address.

116. Some of the objectives of the fundamental service review have been achieved and many have been effective in supporting children and young people and preventing them from entering the care system. This includes the multi-systemic therapy team, family group conferences and the work of the crisis intervention service, which operates an out-of-hours service and provides immediate support to young people on the edge of care. In addition, work has been successful in reducing drift and delay and securing permanency for children who become looked after. This has been achieved for many children through good use of parallel planning, timely use of the Public Law Outline and improvements in the quality of parenting assessments for the court. An increasing number of children are being placed for adoption, and planning for permanency has improved. The Children and Family First teams were also established as a result of the review, and have resulted in an increased number of early help assessments.

117. Training is widely available to staff, including specialised training to develop skills and expertise such as training for the Court Based Assessment Service provided by the Tavistock Clinic. A small minority of staff report difficulties in attending training due to high caseloads. Training for managers requires further development as there are only limited opportunities available for their professional development.

118. There is now a strong cross-party political consensus to drive improvements within children's services. Deputy Cabinet members are in place to drive improvements and there is currently a task and finish group including elected members, officers and young people, to consider how children's views can inform and improve services for looked after children ; for example, there is acknowledgement that a greater priority needs to be given to life story work. Members fulfil their corporate parenting responsibilities well and there are good and cogent examples of corporate parents promoting and supporting looked after children and young people to succeed, including financial support for young people to progress into higher education. Looked after children report that they know the elected members well and feel supported by them. The lines of accountability between the Chief Executive, Executive Director of the People Directorate (DCS) and Lead Member are strong. Linkages between the Health and Well Being Board, the Coventry Safeguarding Children Board and the Joint Commissioning Board are not yet well embedded, although work is in progress to establish clear reporting and accountability.

119. The establishment of the People Directorate has provided opportunities to commission services holistically, exemplified by the current tender process to provide support and accommodation to victims of domestic abuse. The tender includes services for victims and their children as well as perpetrators. Under the established Children and Young People Commissioning Group there are examples of cost-effective commissioning arrangements. These include the re-

commissioning of tier-two mental health services, which has expanded service provision and established a single point of entry for children and families. Such work was informed by analysis of data and consultation with key stakeholders, including children, young people and their families.

What the inspection judgements mean: the local authority

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

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

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

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

Section 2: The effectiveness local safeguarding children board

The effectiveness of the LSCB is inadequate

Priority and immediate action

120. Ensure that partners, including childrens social care, health and police, fulfil the responsibilities for their roles as set out in Working Together to Safeguard Children (Department for Education, 2013) to ensure that effective practices are in place to safeguard and promote the welfare of children in Coventry.

121. Ensure that there is a timely response from partners to actions identified in serious case reviews, and that this results in an improvement in outcomes for children.

122. Ensure that all partners are fully engaged in the delivery of the Prevention and Early Intervention Strategy, so that children and their families have timely access to early help support.

123. Ensure the practice and quality assurance sub-group utilise all information available, including audit findings and performance management information, to undertake a robust analysis of the effectiveness of services to help and protect children.

Areas for improvement

124. Ensure young people's views routinely inform service improvement

125. Promote awareness of private fostering to ensure that more privately fostered children and young people are identified and supported.

Key strengths and weaknesses of the LSCB

126. The CSCB is not effective in ensuring that partners always work together effectively to ensure safeguarding arrangements safely reduce risk for all children identified as needing assessment, support and intervention. Insufficient progress has been made in some aspects of multi-agency working between the police, children's social care and health, particularly at an early stage, when children's needs are first identified. For example, very few health visitors undertake CAFs, and this means that some young children do not have their needs assessed at an early enough stage to prevent problems from getting worse. Some issues identified in a recently published Serious Case Review action plan, for partners to take robust action have not been addressed quickly enough; for example, partnership work between police, health and children's social care to tackle concerns relating to the joint screening of domestic abuse notifications has been slow to develop. In addition, delays in the recording and distribution of strategy meeting minutes remains a problem.

127. The chair of the Board has challenged strategic partners on key issues, but this has not been effective in ensuring timely improvement in some key areas of work. Concerns remain about the availability of police for strategy discussions and attendance at initial child protection conferences.

128. While promoting awareness of private fostering arrangements has been a priority for the Board, the number of children known to partners who are privately fostered remains extremely low, and actions to promote agency awareness of this issue have not yet had an impact.

129. The early help offer in Coventry is not yet effectively coordinated. Partners have been too slow to take on full responsibility for their roles in promoting the welfare of children at an early stage. In recognition of this, the LSCB convened two multi-agency summits in the Autumn of 2013 at which, with the support of the DCS and the Chief Executive, they secured the sign-up of partner agencies to the Prevention and Early Intervention Strategy. However, the strategy and the early help offer should have been in place at a much earlier stage, and it is only now due to be implemented. These recent developments are yet to have an impact on the high rate of referrals into children's social care and this is a key area for development for the Board.

130. Over the past twelve months, the Board has developed and monitored a range of multi-agency procedures, including the well-regarded threshold document and inter-agency safeguarding procedures. A set of supervision standards have been developed and are currently being rolled out within agencies across the partnership. Systematic review of the impact of the Board's work, however, has not been undertaken and therefore the CSCB cannot be assured that activity has led to improvement in practice to safeguard children.

131. The Board has made two notifications to the Department for Education (DfE) this year, one of which is progressing to a serious case review and the other is awaiting a decision. One serious case review has been published in 2013 and two others have been completed and are awaiting publication.

132. Following a recent serious case review, there has been more focus on safeguarding in schools. Learning from serious case reviews has been incorporated into the safeguarding training programme for schools. The Safeguarding of Children in Education Subgroup monitors education staff's attendance at CSCB training and briefing events and provides follow-up briefings for those not present. The CSCB is currently auditing all schools to ensure compliance with the recommendation from a recent serious case review that schools ensure a robust system exists for the recording of injuries or concerns about a child, and that staff are clear about the role of the designated teacher and that this role is used appropriately. Learning from serious case reviews has also been widely disseminated to a range of professionals through training workshops, the CSCB annual conference, leaflets and posters across the partnership.

133. A comprehensive multi-agency training programme has been delivered by the CSCB during the past twelve months. This has covered a broad range of safeguarding issues, including factors relating to severe emotional abuse and neglect (highlighted as a recommendation within the recent high-profile SCR) and issues of diversity, such as Female Genital Mutilation, honour based violence and forced marriage. Training programmes are routinely evaluated and updated and inspectors saw evidence that this training was having a positive impact in some areas in improving practice with children and families. For example, staff spoken to during the inspection reported that training on the findings of serious case reviews had raised their awareness of the need to routinely use interpreters to speak to children alone, and there was clear evidence of this practice being utilised in case files seen.

134. The CSCB works effectively in partnership with Warwickshire Safeguarding Children Board to engage faith groups and voluntary organisations across both areas to ensure that staff in these organisations have a full understanding of their safeguarding responsibilities and know what to do if they have concerns about risks to children.

135. The CSCB has delivered against a number of targets throughout the past 12 months. They have improved aspects of information sharing between the police and schools, and a system of electronic sharing of all domestic violence notifications from the police to all schools is now established. This information includes specific guidance on what action schools should take to promote the welfare of children, and is leading to increased take up of CAF by schools and some good outcomes for children.

136. The CSCB has recently driven improvements to raise awareness amongst children, young people and professionals of the nature and extent of issues for missing children and those at risk of CSE. A variety of approaches have been used to raise awareness and minimise risk for young people at risk of sexual exploitation. For example the 'See something, say something' initiative has led to specific work across the police, licensing, children's social care, health and safety, and the fire service, to target bed and breakfast establishments that are causing concern. 'Chelsea's Choice', a drama piece to increase awareness of the risks of sexual exploitation, has been delivered to young people across the city in secondary schools, colleges, care homes and the YMCA. While there is much evidence of positive feedback from these initiatives, the impact has not been evaluated yet.

137. There is, some good evidence of the CSCB consulting with young people to inform the development of some individual projects, for example, involving young people in the development of a leaflet to raise awareness of child sexual exploitation and of children's experiences informing training, for example in relation to Female Genital Mutilation and Forced Marriage. However there is less evidence of young people's views being routinely sought to inform service improvement.

138. The CSCB annual report provides information about activity undertaken by the Board over the year 2012–2013, including lessons learned from SCRs and child deaths. However, outcomes from individual agency safeguarding audits undertaken in spring 2012 have not been included, and an overview of work in relation to the investigations of allegations against professionals does not feature within the report. Although performance data are included within the report, these are not linked to an assessment of the performance and effectiveness of local services, so that the increasing level of demand for children's social care is not analysed or addressed in detail.

What the inspection judgments mean: the LSCB

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

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

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

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

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