Leicestershire

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: 14 November 2016 to 8 December 2016

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Children's services in Leicestershire 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	Requires improvement
	2.2 Experiences and progress of care leavers	Requires improvement
3. Leadership, management and governance		Requires improvement

[1] Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and 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

Children's services in Leicestershire require improvement to be good. Though the local authority has established cross-party support for children's services' priorities and this has delivered resources for some key services, such as early help and placement sufficiency, other services have not been adequately resourced or effectively led. This has been recognised by the interim director of children's services (DCS) and the interim assistant director for social care who have provided a catalyst for recent improvement work. However, some developments are too new to have had a positive impact, and gaps remain in the quality and consistency of performance data and first-line management oversight and scrutiny.

Children who are at risk of significant harm are identified and protected**.** However, children potentially in need are not seen in a timely manner and experience delay in receiving the help that they need. Thresholds are not yet applied consistently and, in a small number of cases, inappropriate management decision-making after a section 47 enquiry meant that initial child protection conferences (ICPC) were not convened. This has been acknowledged by the local authority and, during the inspection, it took appropriate steps to both strengthen capacity and improve processes in its First Response Service.

The children's service workforce is relatively stable and a workforce strategy is in place. However, there is insufficient focus on social workers, and there is a lack of developmental programmes for practitioners and first-line managers. This has contributed to an inconsistent application of practice standards when assessing and planning for children. Some social workers are not experiencing regular supervision meetings and, when supervision does take place, it is often not sufficiently directive or reflective. Senior managers are monitoring the regularity of supervision, which is now supported by a reflective group approach. Caseloads in some areas are high, but funding has just been agreed to increase the social work establishment, with the aim of ensuring more manageable caseloads.

An evidence-based model of practice has been implemented across the service and is well embedded. This has been used to engage children and their families in the assessment and planning process better and to ensure that their views are secured. However, the quality of assessments is not yet consistently good, with too many lacking sufficient depth and not informed by meaningful chronologies. Care plans are not specific, measurable, achievable, realistic and timely (SMART) and too many support plans for children returning home or discharged from care, subject to a special guardianship order or adoption order, are insufficient to promote sustainability.

The application of the local authority's quality assurance and improvement framework has had some positive impact, for example, with regard to early help evaluation, improvements in placement quality and stability and improved timeliness of children looked after initial health assessments. However, inappropriate processes

operating in the First Response Service have led to the reporting of inaccurate data with regard to contacts, referrals, assessments and their timeliness and the numbers of children allocated. This has prevented the local authority from understanding the true volume of work in this service area and from identifying delays in visiting children.

The local authority's early help offer provides a broad range of effective support and preventative services for children and their families and includes provision of intensive family support. This is having a positive impact on preventing the need for children to become looked after. Work with children at risk of child sexual exploitation is strong, both strategically and operationally, through both mainstream and dedicated services. Although the work to protect children going missing is improving, it lacks consistency, particularly for children looked after, who are not always offered a return home interview or have plans strengthened to mitigate the risks of going missing. While there were some examples of good holistic assessments of disabled children, which led to robust packages of support, their plans are reviewed by non-social work qualified staff and not always based on up-to-date assessments. This means that the local authority cannot be assured that these children's needs continue to be identified effectively and met.

As a corporate parent, the local authority, together with partner agencies, is improving health and education outcomes for children looked after. The quality of placements is good, and unaccompanied asylum-seeking children are supported by a dedicated team that ensures appropriate consideration of their needs arising from diversity. However, timely access to mental health services is unavailable for too many children looked after, and permanence planning is significantly weaker for those who are achieving permanence through options other than adoption. Adopters are appropriately assessed and well supported to the point of the order being granted. At this point, as with children for whom special guardianship orders are granted, meaningful support to the child and their family ceases to be on offer.

The local authority demonstrates considerable commitment to engaging with children and young people and ensuring their participation, involvement and influence over the shape of service delivery. In so doing, they work collaboratively with a range of young people's representative groups, including two Children in Care Councils (CiCCs) and the Supporting Young People after Care Group. Two members of the CiCC co-chair the corporate parenting board. There are two children's rights officers providing an effective advocacy service for children looked after and for children who are the subject of a child protection conference. A wide range of well-received and well-attended activities are facilitated by a participation officer.

The majority of care leavers are well supported to make the right choices and to live independent lives. The local authority maintains very good contact with them and has worked with partners to improve the range and quality of accommodation available. All care leavers spoken to feel safe in their accommodation. The quality of pathway planning is, however, not consistent, and the support offered by personal

advisers is too variable. Too few care leavers, particularly the most vulnerable, secure a place in further education, employment or training.

Contents

The local authority

Information about this local authority area

Previous Ofsted inspections

- The local authority operates one children's home, which was judged as requiring improvement to be good in its most recent Ofsted inspection.
- The previous inspection of the local authority's safeguarding arrangements was in May 2012. The local authority was judged to require improvement.
- The previous inspection of the local authority's services for children looked after was in May 2012. The local authority was judged to be good.

Local leadership

- The chief executive of Leicestershire County Council has been in post since April 1994.
- The interim DCS has been in post since July 2016.
- The chair of the Local Safeguarding Children Board (LSCB) has been in post since Feb 2012.
- The LSCB is joint with Rutland.

Children living in this area

- Approximately 134,800 children and young people under the age of 18 years live in Leicestershire. This is 20% of the total population in the area.
- Approximately 11% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 9% (the national average is 17%)
  - in secondary schools is 8% (the national average is 15%).
- Children and young people from minority ethnic groups account for 12% of all children living in the area, compared with 22% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Asian or Asian British and Mixed.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 8% (the national average is 20%)
  - in secondary schools is 7% (the national average is 16%).

Child protection in this area

- At 14 November 2016, 2,145 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 2,266 at 31 March 2016.
- At 14 November 2016, 397 children and young people were the subject of a child protection plan. This is an increase from 345 at 31 March 2016.
- At 14 November 2016, 12 children lived in a privately arranged fostering placement. This is an increase from a suppressed number at 31 March 2015.
- Since the last inspection, 10 serious incident notifications have been submitted to Ofsted and five serious case reviews (SCRs) have been completed or are ongoing at the time of the inspection.

Children looked after in this area

- At 14 November 2016, 495 children were being looked after by the local authority (a rate of 36.7 per 10,000 children). This is an increase from 470 (35 per 10,000 children) at 31 March 2016. Of this number:
  - 134 live outside the local authority area
  - 47 live in residential children's homes, of whom 42% live out of the authority area
  - two live in residential special schools[2], of whom 100% live out of the authority area
  - 369 live with foster families, of whom 25% live out of the authority area
  - 13 live with parents, of whom 31% live out of the authority area.
- 30 children are unaccompanied asylum-seeking children. In the last 12 months:
  - there have been 41 adoptions
  - 16 children became the subject of special guardianship orders
  - 106 children ceased to be looked after, of whom 1% subsequently returned to be looked after
  - 11 young people ceased to be looked after and moved on to independent living
  - five young people ceased to be looked after and are now living in houses in multiple occupation.
- The local authority utilises the 'Signs of Safety' practice model in their assessment and care-planning process.

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

Recommendations

1. Ensure that performance management information is based on accurate data, so that all areas requiring improvement can be identified and progressed in a timely way.

2. Ensure that management oversight of practice fully complies with supervision policy requirements and supports effective case progression and decision-making.

3. Ensure that when a child is allocated to a social worker this is reflected in the social worker's caseload and that caseload size and management capacity across the service facilitate good-quality social work.

4. Review processes operating in the First Response Service to ensure the accurate recording of contacts, referrals, assessments and their timeliness.

5. Ensure that practitioners and managers understand and apply thresholds appropriately at every stage of the child's journey.

6. Ensure consistency in social work assessments, so that they are sufficiently in depth, are informed by good-quality chronologies, reflect the needs and identities of individual children, are updated regularly to take account of children's changing needs and circumstances and lead to outcome-focused plans.

7. Strengthen arrangements for permanence planning to enable all children looked after to be provided with a permanent home and family without undue delay, wherever this is possible.

8. Ensure that children looked after are able to access timely and appropriate support to meet their therapeutic needs.

9. Ensure that all children looked after who go missing are offered a return home interview and that information gained from all such interviews is used to inform risk management and shared intelligence.

10. Ensure that, when a child in need plan relating to a child who has disabilities is reviewed, it reflects an up-to-date assessment, informed by the voice of the child and undertaken by a qualified and registered social worker.

11. Ensure that support plans for special guardians and adopters are informed by a clear assessment of children's and carers'/parents' long-term needs and that good-quality specialist post-order support is made available to those affected by adoption and special guardianship when, and for however long, it is needed.

12. Improve the quality and management oversight of pathway planning and ensure consistency in the quality of advice and support provided by personal advisers to care leavers. This should include information about entitlements and provision of health histories.

13. Ensure that practice for children who are subject to private fostering arrangements meets statutory requirements and that all staff and partners know how to recognise and notify a private fostering arrangement.

14. Improve assessment and care planning for children on the edge of care or returning home, so that it is clear how positive change is to be achieved and sustained.

15. Comprehensively review the current strategic plan for those young people not in education, employment or training (NEET), to ensure that a higher proportion of care leavers move to sustained education, employment or training.

16. Ensure that when homeless young people aged 16 and 17 need to be accommodated under section 20 of the Children Act 1989 that this is effected without delay.

17. Ensure that appropriate developmental programmes are in place for experienced and qualified staff, particularly for senior practitioners and first-line managers, and that the assessed and supported year in employment (ASYE) programme is appropriately overseen.

Summary for children and young people

- Inspectors found that services for children in Leicestershire are not yet good. Managers know where they need to improve services and already have some plans in place.
- Most children and families in Leicestershire receive help when they need it. Most of the time, social workers take quick action when children need help and protection. Many different services in Leicestershire give good support to families early on, to stop their difficulties increasing.
- Most children have an up-to-date assessment of their needs, but plans do not always help families to understand what needs to change.
- When there are difficulties for children to live with their families, children and their families can receive a lot of support to prevent the need for the children to live in an alternative home. Sometimes plans are not made early enough, which means some children live in difficult situations for too long.
- There are strong relationships between children and their social workers. Social workers work hard to understand the wishes and feelings of children, but sometimes children's views do not inform plans and actions.
- Nearly all children looked after go to a good school, and their attendance is good.
- Social workers ensure that children looked after have plans in place to help to keep them healthy.
- Children looked after understand what has happened to them and why they are not living with their families.
- Children live in good-quality placements. Well-trained foster carers provide good support to help to meet children's and young people's needs.
- Decisions are not always made quickly enough to find the right family for children who are adopted. Children adopted live with their brothers and sisters when possible.
- When children leave care through a special guardianship or adoption order, they often do not get the support that they need.
- Most young people who are leaving care value the support that they receive from their personal advisers, and live in safe and suitable accommodation.
- Leicestershire takes children's views seriously and has a range of creative ways to obtain these, so that they influence ways in which services are run. There is an effective children's rights service, and children are helped to participate in meetings that concern them.
- Children told inspectors that they value the opportunities that being looked after has given them and enjoy the activities that enable them to mix with other children looked after.

The experiences and progress of children who need help and protection	Requires improvement

Summary

Children who are at risk of significant harm are identified and protected and, when children are assessed as being in need, they are provided with effective interventions. However, Leicestershire does not have an effective enough response to referrals to ensure that all vulnerable children receive a timely service. Decision-making regarding the need for a multi-agency initial child protection conference has not always been sufficiently robust. The quality of multi-agency working, when there is a safeguarding concern about a disabled child, needs strengthening.

The quality of assessments and plans is variable. Too many assessments lack depth and a clear analysis of children's needs. Plans often do not set out clearly enough what parents/carers need to do to change and by when. Assessments and plans are not consistently sensitive and responsive enough to issues of identity and diversity. A culture of children being seen and their voices secured is well established across services although, in a small number of cases, it was not clear how the views of children had informed planning.

A wide range of early help and targeted support is available for families when they need it, and this includes 24/7 intensive family support. There is evidence of positive impact for most children.

Child protection plans are mostly reviewed effectively by child-focused independent reviewing officers (IROs) and have strong multi-agency attendance and contribution. Timeliness has improved, and a very high proportion of initial child protection conferences are held within required timescales. The number of repeat child protection plans is high, although reducing, and these mainly relate to pre-existing concerns, which suggests that safeguarding issues have not previously been addressed sustainably.

When a child is at risk of sexual exploitation, this is identified early with usually robust plans put in place to reduce risk. Effective multi-agency risk assessment conference (MARAC) and multi-agency public protection arrangements (MAPPA) are in place, and there is an appropriate range of services for families affected by mental ill health, domestic abuse or substance misuse. Arrangements for 16- and 17-year-old homeless young people are not robust enough to ensure that young people vulnerable to homelessness are always supported effectively in a timely way.

Numbers of children identified as living in private fostering arrangements are low, and arrangements to ensure that these children are safeguarded are weak.

Inspection findings

18. The First Response Service does not provide an effective enough response to contacts and referrals to ensure that all vulnerable families receive a timely response to concerns and needs. High caseloads and insufficient management oversight result in some children with lower-level needs not receiving the help that they need soon enough. (Recommendation)

19. Contacts that result in the provision of advice or signposting are not recorded and, as a result, the number of recorded contacts is low. This means that the local authority is not capturing the true level of demand, and some of the child's history may be missed in a subsequent assessment of need. The decision of whether to progress to assessment is not taken until after the first visit to the child and family, which means that all the information gathered up to and including that point is often not counted as an assessment. This is having an impact on the quality of data reported, concerning both the number of assessments undertaken and their timeliness, and severely limits the usefulness of current performance data. (Recommendation)

20. Thresholds are not applied consistently enough. A small number of children who should have been referred for a social work assessment were directed to early help in the First Response Service. There were examples of threshold decisions being challenged effectively by the early help service, but this could not prevent delay in children receiving the right service at the right time. Inspectors identified a small number of cases that should have resulted in an ICPC, but which were transferred inappropriately to early help or child in need teams. The local authority took immediate and robust action to address this finding and to improve decision-making in this area. (Recommendation)

21. Children who are at risk of significant harm are identified and protected. The Urgent Response Team within the First Response Service delivers a timely and child-focused service for children at risk of significant harm. This team has established a solid and effective joint-working partnership with the police, with which they are co-located, as well as with other agencies.

22. Decisions about concerns for disabled children who are at risk are not always informed by all relevant information held by partner agencies. For example, key agencies, such as the police, are not always involved in initial strategy discussions. This has an impact on the quality of assessment, risk analysis and management decision-making. In a small number of cases, single investigations were undertaken when a joint investigation was appropriate, though this did not leave these children at risk of significant harm. (Recommendation)

23. The integration of the out-of-hours team into the First Response Service is a strength. The team responds effectively to contacts made out of hours, with

thresholds applied appropriately. However, the issue of lower-level referrals not being dealt with in good time within the wider First Response Service subsequently leads to some children being seen by the out-of-hours team when situations have escalated. This is not good practice and leads to interventions being more intrusive for the child and their family than they need to be.

24. The local authority has focused on and invested in early help support. Engagement with families has increased, and a wide range of early help support is available for families when they need it. Experienced workers in the Early Help Hub, based in the First Response Service, analyse history and presenting issues robustly and have a good understanding of safeguarding thresholds. Most assessments completed by early help workers are of good quality, with clear, outcome-focused plans. The voice of the child is a strong feature in the majority of cases seen. A variety of early help and targeted services is available through a range of interventions, which include group work, brief intervention, targeted intervention by a family support worker and intensive intervention, which is available 24/7. The impact of this work is evaluated and includes feedback from families. This evaluation is indicating a positive impact for the majority of children.

25. The quality of assessments across children's social care is variable. Some are of good quality and result in comprehensive packages of support, but too many are not thorough enough to adequately identify and address all presenting needs. Practice in relation to chronologies needs strengthening as, in most cases seen, planning is not fully informed by important events in the child's life. The needs of some children in larger families are not always clearly articulated in case recordings. Management oversight and supervision is not sufficiently regular or reflective to address these weaker areas of practice. (Recommendation)

26. Strong assessments of the needs of children, undertaken by the Disabled Children's Team, were seen, which evidenced the child's experience throughout and led to robust packages of support. However, many child in need plans are reviewed by non-social work qualified staff and without the benefit of an updated assessment. In a significant proportion, children had not been seen prior to review. This is not good practice, and the local authority cannot be assured that these children's needs continue to be identified effectively and met. (Recommendation)

27. Children in need are supported by the Strengthening Families Teams and most of their work focuses on concerns arising from lower-level neglect. Social workers and family intervention workers are based in these teams, so that more intensive support can be offered to children and their families. Senior practitioners support staff with early identification of families when concerns are escalating, thus ensuring a timely response for those children in need of protection.

28. Support and protection plans are not always sufficiently clear about what parents need to do to change and by when, nor about how families will be supported to effect the required change. This does not promote timely and focused delivery of the plan. Child protection plans are reviewed by child-focused IROs and there is strong multi-agency attendance and contribution. Families are engaged and involved, and there is clear attention on the child. However, in a small minority of cases, independent review is not challenging and proactive enough to ensure that plans progress effectively. Timeliness of ICPCs has improved. In 2015–16, those held within 15 days of the strategy discussion, initiating a section 47 enquiry, were reported as 79%. The local authority latest data shows a much-improved position at 97%. (Recommendation)

29. The rate of repeat child protection plans is above that of similar authorities. The local authority is aware of this and has taken action to review and improve decision-making in this area. In most cases, repeat plans relate to pre-existing concerns, suggesting that safeguarding issues had not been fully addressed previously in a sustainable way. The local authority is aware of this and is currently placing a strong emphasis on delivering sustainable progress for these children, before child protection plans are ended, including making more proactive use of legal planning meetings, where appropriate.

30. Children being seen and the voice of the child heard are key elements of good practice culturally embedded across services. The most recent local authority data indicates that 96% children have been seen as part of the assessment process. Interventions draw on an evidence-based model of practice, which is consistently applied and which supports direct work with children. This is a real strength, which can be built on, and evidences a strong child focus and commitment to improving the lives of children. As a result, many children benefit from strong relationships with their social workers who know them well.

31. Older children are encouraged to attend and contribute to their conferences. They are increasingly supported by a children's rights officer who provides an effective advocacy service to all children, aged 10 or over, who attend a child protection conference. This is having an increasingly positive impact on the growing numbers of children attending child protection conferences, with 17 children attending child protection conferences in the last quarter. 14 children were also supported to write a report for their conference. As a result, children are empowered and have their voices heard within the child protection process. A tool to evaluate the impact of advocacy has been developed, informed by the views of children and young people and will be implemented shortly.

32. Services are not consistently sensitive and responsive enough to issues of identity and diversity. Some examples of good practice were seen in work with

a young transgender person, unaccompanied asylum-seeking children and children from a traveller background.

33. Much has been done to promote awareness of child sexual exploitation, female genital mutilation and trafficking, and there is evidence of this having an impact in terms of increasing numbers of appropriate referrals. A multi-disciplinary team has been established to work alongside the police to identify, safeguard and protect children at risk of child sexual exploitation, being trafficked or having gone missing or run away. The team provides a victim-centred approach, combining criminal investigation, safeguarding and education programmes. Concerns and referrals are jointly triaged with the police, to agree appropriate safeguarding action. The team undertakes specialist assessments, leads on the development of risk management plans and monitors and tracks cases where there are concerns about child sexual exploitation and/or where children have been reported missing. The majority of cases are co-worked with social workers in the child protection teams. Decision-making by the child sexual exploitation team reflects a clear child focus on risks, supported in most cases by good use of a child sexual exploitation risk assessment tool. Work undertaken by the team is appropriately tailored to individual needs, and risk reduction was evident in the majority of cases.

34. Operational practice is strong with regard to children missing from home, with the child sexual exploitation team coordinating return home interviews and regular meetings taking place to consider missing episodes and to agree risk management plans. The majority of return home interviews are timely and include clear risk analysis, immediate safety planning and recommendations for future actions. The local authority has a clear grasp of pupils missing from education, with trends and patterns understood, including prevalence in schools with higher incidents. It communicates well the need for schools to monitor absences and to report concerns promptly. Schools readily accommodate these requests. The last data return elicited a 100% response rate. Some 370 children are currently electively home educated. In these instances, local authority staff conduct monitoring visits or make contact by telephone, to ensure that parents are providing appropriate educational activity. Managers liaise with the school admissions and social care teams to identify and prioritise visits to families that may be considered vulnerable. Children who have medical needs are known to the local authority and supported in their journey back to full-time education by specialist tutors.

35. Children and young people living in households in which at least one parent or carer misuses substances or suffers from mental ill health, or where there is domestic violence, feature strongly both in new referrals and in children becoming subject to a second or subsequent child protection plan. The majority of repeat child protection plans examined related to pre-existing 'toxic trio' concerns. The MARAC and MAPPA are effective, with a strong commitment to information sharing and challenge by agencies. A good range

of services is in place, which include the 360 project, commissioned by police, that provides a support service to victims; Women's Aid; the Freedom Programme; a recently commissioned service for perpetrators of domestic violence; and Turning Point, a substance misuse service, offering one-to-one support, prescriptions, group work, complementary therapies and individual and family support.

36. Arrangements for 16- and 17-year-old homeless young people are not applied in a timely manner. Although young people are appropriately offered section 20 accommodation, assessments are not always thorough or swift enough, and young people do not always receive help and accommodation in good time. This means that some young people are left in vulnerable living situations for too long. (Recommendation)

37. The numbers of children known to be in private fostering arrangements in Leicestershire are low. Of the 10 currently notified, eight are foreign students residential at a local college. Management direction is not evident, and statutory checks or assessments are not apparent in some cases and subject to delay in others and so the local authority cannot be fully satisfied that the well-being of these children is assured. No single worker or manager takes responsibility for overseeing private fostering arrangements. There is no annual report on private fostering for 2015–16 available, and it is not clear who currently has a strategic overview of this area of work. (Recommendation)

38. Allegations of abuse, maltreatment or poor practice by professionals or carers are taken seriously and, in all cases examined, the appropriate threshold was applied and a timely response was evident.

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

Summary

Children only become looked after if their needs require this. Early prevention and intensive family support are ensuring that a lower number of children need to be looked after than the national average. Support for children on the edge of care and those returning home, however, is insufficiently focused on effecting and sustaining positive changes. Although there are some delays in the early stages of adoption planning, children are well matched with their future adoptive parents and mostly placed within a reasonable timescale. Routes to permanence other than adoption are much less secure and children experience too much uncertainty during this process. Post-care support for both adopters and special guardians is weak and fails to properly consider children's and carers' future needs.

The local authority has a robust and effective approach to placement commissioning and monitoring. As a result, placement choice and matching have improved. Out-of-authority placements are regularly checked for quality and contract compliance. Foster carers feel well supported and can access a range of useful training opportunities. Unaccompanied asylum-seeking children receive a good and sensitive service.

Social workers undertake constructive direct work, which helps children to understand their histories and express their views. Contact with family members is well supported. Children are not always visited by social workers as often as they would wish or, in some cases, in line with statutory requirements. Assessments are not routinely updated, and care plans sometimes are not specific enough. Staff working with children looked after have a good awareness of the risks of sexual exploitation, which leads to risks being identified and addressed early. However, when children go missing, they are not always offered a return home interview and, when they are, these are not used well to inform planning.

Most children receive regular health assessments and have a good quality personal education plan (PEP) that helps them to make progress with their education. There is, however, a lack of timely therapeutic support for children looked after. Children appreciate the opportunities that being looked after gives them, particularly to participate in leisure and social activities. There are two active CiCCs, which are valued both by the children who take part and by senior leaders.

When young people looked after leave care, services are effective in keeping in touch with nearly all of them. Some receive a good service from committed personal advisers, but overall the quality of support is too inconsistent and there is insufficient management oversight and direction of the services being provided.

Inspection findings

39. Leicestershire has prioritised investment in preventative services to help to avoid the need for children to become looked after. Children who are at risk of family breakdown receive timely and, if necessary, intensive support to help them to remain living with their families. As a result, children only become looked after when it is clearly in their best interests or is necessary to ensure their safety. These decisions are based on clear, risk-based assessments. When children become looked after, there is effective placement matching supported by good-quality information about children's needs and an efficient approach to family finding. As a result, children experience high-quality care, and placement stability is improving.

40. Children do not return home unless it is safe and in their interests to do so and they receive help to support a successful return. However, the quality of assessment and planning of this work is too variable. Some good-quality work leading to successful outcomes was seen by inspectors. In other cases, it was not clear how improvements were to be achieved or sustained. This was also true of some of the preventative work undertaken with children on the edge of care, although in no cases were children left at risk of harm as a result of these weaknesses. (Recommendation)

41. Although workers, overall, know their children and their needs well, many children do not have an up-to-date assessment. Most have a care plan, but the quality of these is too variable. While most care plans address a range of needs, actions are often too broad and lack timescales. As a result, these plans are not effective in helping to drive improving outcomes for children, particularly achieving permanence. Direct work undertaken by social workers is usually of a good standard and this helps children to understand what has happened to them and to express what they want to happen. Due to competing demands and, for some workers, excessive caseloads, not all children are visited as often as the statutory minimum standard defines, and most children spoken to wanted to see their social workers more often. While managers are viewed as supportive, their oversight and supervision are too infrequent and not addressing practice shortfalls effectively. (Recommendation)

42. Statutory reviews are timely, inclusive and well managed. IROs work hard to involve children in review processes appropriately, although a number of children and young people spoken to describe them as too adult-dominated. IROs challenge on behalf of children, when services are not meeting their needs, escalating cases to senior managers and the Children and Family Court Advisory and Support Service (Cafcass) if necessary. They are not, however, always challenging drift effectively, for example, in progressing permanence plans. In part, this is because high caseloads result in their not being able to track cases between reviews effectively. Children have access to an excellent advocacy service, although not all are aware of this or have confidence in the

complaints process. Similarly, while good-quality information has been developed to inform children of their rights and entitlements, not every child spoken to reported having access to this.

43. The local authority considers permanence at an early stage for children who are unable to return home or to their birth families. For some children, these considerations are not followed through effectively or progressed in a timely manner. Delay is most apparent for children who cannot be adopted or return home. Foster placements assessed as providing short-term placements can become long-term placements without clear planning and matching. While these placements are often with committed carers and meeting the current needs of children well, it was less clear whether they were really offering permanence for children rather than long-term care. In some cases, the need for permanent carers was identified, but family finding was not successful in identifying a suitable match. These shortfalls mean that children have experienced considerable periods of uncertainty about their future care. The local authority has recognised the need to track and monitor all plans earlier and more effectively. It has recently undertaken a review of all children accommodated under section 20 of the Children Act 1989 and has established a permanence panel to ensure that early permanence decisions are made and plans are progressed. This is too recent to evidence impact. (Recommendation)

44. Public Law Outline processes are used consistently and effectively to assist timely decision-making and ensure that families are clear about what is needed to avoid legal intervention and the consequences of not complying. Options for children to live within their extended family are appropriately explored and considered and, when returning home is a viable option, this is actively pursued. In a small number of cases, however, these decisions have been made without thorough consideration of whether this was the best option. More commonly, too little attention is given to the support that may be needed over the longer term. This is particularly acute with children who are subject to special guardianship orders and whose cases are routinely closed only three months after the order was made without any clear plan as to how future issues should be addressed. (Recommendation)

45. The local judiciary and Cafcass report open and constructive relationships with the local authority and that the quality of social work reports has improved, with most being satisfactory or better. Agencies work together effectively to reduce avoidable delay. In a small number of cases, inspectors found that local authority managers and solicitors had not been sufficiently robust in presenting their assessment and proposed plans to the court and had amended these too readily when challenged.

46. When a child is at risk of sexual exploitation, this is identified early with usually robust plans put in place to reduce risk. Responses to children going missing are, however, much less consistent. Although there have been some

recent improvements, children who go missing are not consistently offered a return home interview, and those that do take place are often poorly recorded with little evidence that they are being used to inform safety planning. This is particularly the case for children placed out of authority, who may be among the most vulnerable. (Recommendation)

47. Children looked after seen by inspectors spoke very powerfully and positively about the opportunities that becoming looked after had given them. These include access to a range of leisure activities, participation in an excellent choir for children looked after and other activities in which they can meet and socialise with other children looked after. A particularly positive initiative is 'Time2Spend', through which any child can apply for an additional £150 funding for a leisure activity, with all decisions made by the CiCC. There are also good opportunities to be consulted on and to influence service developments. These include two well-supported CiCCs, involvement in staff and carer selection and the corporate parenting board, which is co-chaired by children looked after. Local authority leaders clearly value and take seriously the views of children looked after.

48. Services for children needing therapeutic support are much too variable. Some children receive good support from specialist children looked after child and adolescent mental health services (CAMHS) and others benefit from good-quality therapeutic placements. Too many children are, however, waiting too long for the necessary support from CAMHS, and there is a lack of alternative provision to meet therapeutic needs. One child spoken to described a catalogue of recent appointments cancelled without explanation, and another a long wait for an appointment, which left her feeling that 'nobody cares'. Social workers commented that current service thresholds are too high and too rigid. Difficulties in accessing the right CAMHS support was also a common theme for children placed out of authority. (Recommendation)

49. Provision to meet children's physical health needs is much better. The local authority and its health partners have taken effective action to improve children's access to health assessments. At 31 March 2016 the percentage of children who had an annual health assessment was 90.6% – an increase of 5.8% compared with 31 March 2015. Performance is currently well above the national average, and a large majority of children receive regular, good-quality health assessments, which are used to promote improved health. Performance regarding children who have up-to-date immunisations and dental checks, however, deteriorated in 2015–16, and the number of strengths and difficulties questionnaires completed is low, although performance is improving in this area.

50. The local authority has a strong commitment to keeping all children safe from bullying and has done some excellent work promoting anti-bullying in schools. Designated safeguarding teachers attend mandatory training, and there is good advice available to schools and governors about spotting and dealing

with any bullying that may occur in schools. When bullying is identified as a potential issue for children looked after, it is dealt with quickly and well. The CiCC has also developed an anti-bullying leaflet.

51. School attendance by children looked after is good and has been stable over the last three years. There have been no permanent exclusions over the same period. Fixed-term exclusions are less stable, with a slight increase in 2014–15. However, there is a good shared focus between schools and the virtual school on this issue, which is successfully reducing the numbers. The attainment gap between all children and those looked after remains too wide, but many make good progress socially, emotionally and educationally, considering their starting points. The local authority has invested well in the highly effective virtual school. Schools speak highly of the support and challenge provided by tenacious virtual school staff who help to build teachers' capacity to ensure that children have an enjoyable and productive time in school. Virtual school staff use their specialist expertise and knowledge to train teachers and school governors. PEP review meetings are very well organised, effective and well attended. Outcomes from the meetings are clearly expressed, and actions are followed up. Virtual school staff attend all out-of-area PEP meetings and apply equally high expectations. Pupil premium plus funding is well targeted and closely monitored by virtual school staff. Children's progress is extremely well monitored.

52. Most children are living in safe and caring homes, which meet their current needs well. Placement stability both for the short- and longer-term measures has improved and is now close to the average of statistical neighbours. When in line with children's needs and wishes, contact with parents, brothers and sisters and other significant family members is well supported and sustained at a meaningful level. Inspectors saw some well-resourced and planned arrangements, which clearly mean a lot to the children involved.

53. Children are only placed in out-of-authority placements when this is necessary to meet their needs. The local authority has good commissioning and placement selection processes and strong arrangements for monitoring both quality and contract compliance, with most placements visited monthly. This promotes value for money and ensures that placements are providing the services required by children. Social workers also visit children in these placements regularly, and they are always visited by the children's rights officer for children looked after. The local authority and its partners are dogged in their attempts to ensure appropriate local education and health provision for these children, but these efforts are not always successful in ensuring swift access to appropriate provision.

54. The local authority has recognised the importance of the agency decision-maker role and the increasing workload arising from ensuring that sufficient numbers of skilled foster carers and adopters are available. In response, a dedicated agency decision-maker role, separate from direct line-management

arrangements, reporting directly to the assistant director for children's services was created. This role has been effective at providing positive challenge and quality assurance, tracking children to ensure that suitable carers are found and the best placements are made for children. The agency decision-maker is aware of practice issues for both adoption and fostering panels and uses the panel business meetings and her permanence panel membership to report gaps back to managers, to challenge and drive performance.

55. The fostering panel is chaired effectively by an experienced chair and panel members represent most of the relevant backgrounds. The panel is responsive to demand and meets twice monthly with occasional extra panels, as required. The quality of mainstream foster-carer reports to panel is consistently good to very good. In contrast, connected person assessments are generally weaker and do not give sufficient attention to children's potential future needs. This has been addressed through training and a new report format template, based on the British Association for Adoption and Fostering form, but these developments are too recent to evidence impact. Insufficient quality in supported lodgings assessments is also being addressed by a requirement to submit assessment reports to panel, and there is evidence that this is beginning to drive improvement in this area.

56. Fosters carers spoken to as part of the inspection were very positive about the quality of support that they receive both through their supervising social worker and by accessing training. They spoke confidently about their roles and about how they are empowered to support and advocate for the children in their care. Foster carers also reported that the fostering service is in a much better place now compared to previous years, with a new management team working hard to make a difference for them and the children they care for.

57. At the time of the inspection, the local authority was caring for 30 unaccompanied asylum-seeking children. These children were receiving a good, dedicated service with sensitive consideration of their cultural and spiritual needs. Good use is made of interpreters, and children are living in suitable placements, including specialist provision, which provides support for their educational needs, and are developing life skills. Workers visit these children regularly, particularly in their first few weeks, to help them to adjust to life in Leicestershire. During the inspection, other examples were seen of exceptionally good work to meet needs arising from disability, sexuality and ethnicity and, in most cases, care was responsive to children's diverse needs.

The graded judgement for adoption performance is that it requires improvement

58. In the 12 months prior to inspection, 41 children left care through adoption. While this number is less than the previous year, at 18% it is still more than the national average of children adopted during 2015−16. The local authority has been successful in the adoption of children from minority ethnic groups, brothers and sisters and very young children. In contrast, efforts to secure adoptions for older children and children who have disabilities have not met with success. The latest published data shows that of 20 children adopted in quarters one and two of 2015−16, over four fifths (84%) are three years old or younger.

59. Some parts of children's adoption processes in Leicestershire take much longer than others. Too much time is taken, on average, in the early stages of adoption planning and in placement matching, although once matched children are speedily placed with their new parents. Tracking for many children has started too late in the process to prevent these early delays. Limited availability of reliable data has prevented effective tracking, but this is now being addressed. (Recommendation)

60. Despite the early delays, overall performance shows that children are moving in with their adoptive families more quickly than in previous years. The 2012−15 adoption scorecard showed that the average time between a child entering care and moving in with their adoptive family was 546 days, 37 days faster than in the 2011−14 period. Leicestershire's performance was 47 days better than the England average for 2012−15 at 593 days, although longer than the national threshold of 487. In-year figures to 31 March 2016 show that Leicestershire is now exceeding the national target at 442 days, with more children moving in with their adoptive family more quickly than in previous years. More children are now entering care and moving in with their adoptive family in less than 16 months. Leicestershire's performance has improved in this area from 57% to 67% in quarters one and two of 2015−16 and is considerably better than the national level of 47%.

61. The adoption service has had considerable success ensuring placements for brothers and sisters together, when it is in their best interests. While affecting the timeliness of placement, 90% (18 of 20) brothers and sisters (groups of between two and four children) have been successfully placed in the last year. The majority of brother and sister assessments seen carefully considered the needs of each child, determining whether it is in their best interest to live with their brothers and sisters. A small number had assessments that were more superficial and based on a checklist approach.

62. The service has embraced foster-to-adopt placements. Nine children have been placed in such arrangements, for six of whom adoption orders have

been made in the last year. This has allowed very young children to avoid placement moves and make early attachments to their primary carers.

63. Leicestershire adopted a freeze on recruiting new adopters initiated in April 2015, at a time when they had 39 adopter households approved. In April 2016, 21 households were available and, at the time of this inspection, this number had reduced to five, none of which is a suitable match for the children currently waiting. As a result of this lack of local recruitment, children potentially wait longer for a suitable match to be available.

64. A specialist assessment team undertakes all assessments of prospective adopters and foster carers. The majority of case records reviewed were of a good standard, fully covering all the required areas. Training covered the relevant areas, providing prospective adopters with an understanding of legal processes and of the implications of parenting a child who has experienced trauma and abuse. All prospective adopters spoke highly about engaging with the adoption process, reporting that it was realistically challenging and prepared them well for their children. They all described the support received during the assessment stage right up to approval in strong, positive terms, such as 'brilliant' and 'excellent'.

65. Child permanence reports seen were generally well written and provided a clear picture of the child, birth family and history. Most reports sensitively outlined the reasons why members of the family were unable to care for the child. This reflects some improvement, following earlier management concerns regarding the quality of these reports. Aspects of these reports still need further work as not all reports clearly outline the reasons for children not maintaining contact with brothers and sisters.

66. The life story work seen draws effectively from the information presented in the child permanence records. Social workers use life story work as a basis to complete direct work with children, and are rightly proud of their work. These information booklets are child-focused and written in a style to help children to understand their early histories and to answer any current or possible future questions.

67. The adoption panel provides robust oversight and makes appropriate recommendations on the approval of adopters, matches and children's plans. There is an experienced panel chair, a good mix of panel members with personal and professional experience of adoption and effective administration. Panel minutes are informative and evidence full discussions with careful consideration of assessments and paperwork pertaining to prospective adopters and matches to children. The agency decision-maker provides robust, well-considered and effective challenge to plans and matches. She has effective tracking systems to ensure that her advice is considered. Panel decisions progress efficiently to the agency decision–maker, and her views and decisions, with any additional comments, are included in minutes.

68. There are clear deficits in the service's delivery of post-adoption services. Although some improvements have been made, these have only taken place in the last two months and are not fully embedded. There remain shortfalls in the provision of support to birth parents both pre- and post-order, failure to provide timely birth records and counselling and a lack of relevant specialist support for adoptive families post-order. While it is clear that the service is aware of these shortfalls, the proposed improvement plans overly rely on universal services, procurement processes and locality teams to address service gaps. These plans fail to demonstrate or appreciate the specific needs of adoptive children and families, birth parents and adopted adults. (Recommendation)

69. Post-order support is either non-existent or extremely poor and has been the subject of many complaints. Adoption support plans are generic, with references to universal services that are not designed to respond to the complex needs of many adopted children and their families. Even with two new workers, there is still a clear lack of direct work or specialist therapeutic services to meet the demand for support. There is no post-approval training offer and no support groups for either children or adults facilitated by the local authority. In response to the local authority's lack of information and support services, a group of adopters has set up its own adoption support group, which now consists of approximately 35 adoptive parents. The local authority has had success in obtaining large amounts of adoption support funding for specific families, a total of £512,000 since June 2015. However, this over-reliance on the adoption support funding falls considerably short of its duties in relation to assessment for and provision of good post-adoption support. (Recommendation)

The graded judgement about the experience and progress of care leavers is that they require improvement

70. The majority of care leavers make positive choices and are well prepared to live independent lives. At the time of the inspection, there were 216 care leavers, of whom the service maintains contact with 92%. Managers were able to account for those with whom the service is not in contact and to set out the actions taken to check on their safety and well-being. Cases are not closed at 21 years of age by managers, until they are assured that care leavers' situations are stable. The local authority provides care leavers with an appropriate level of financial support, and there is tenacious work with unaccompanied asylum-seeking young people. Nevertheless, care leavers report significant variations in the quality of support that they receive from personal advisers. Many benefit hugely from personal advisers who are attentive and approachable and challenge and support care leavers as they move towards independence. Others reported feeling let down, not being

visited often enough and poor communication between personal advisers and managers, leading to protracted decision-making. (Recommendation)

71. Pathway planning requires improvement. The planning process is not one that care leavers view as a key element of their personal journey. Plans, particularly for the most vulnerable who are displaying risky behaviours, do not sufficiently capture the actions and timescales needed to ensure the right level of support. Their oversight by managers is insufficiently robust. (Recommendation)

72. A new risk management panel brings together key agencies, including the youth offending service, police, health and a commissioned service that provides independent specialist information, advice and guidance to targeted groups of young people. It is at a formative stage and seeks to coordinate inter-agency support for the most vulnerable care leavers. Representation and attendance are good and a senior manager brings priority cases to the panel. The service has, however, been late in establishing a process of this nature. Moreover, the terms of reference for the group are insufficiently outcomes-based or measurable.

73. Personal advisers and social workers liaise well and are clear about their respective responsibilities. They ensure that, when appropriate, care leavers who have specific mental health or substance-misuse issues, or disabilities have an ordered transition to adult services. Care leavers are not sufficiently familiar with their personal health histories during their time in care, an issue that the local authority acknowledges needs to be better incorporated into pathway planning. Care leavers spoken to were, however, accessing health services, but commented that they and their peers do not attend for dental checks as often as they should. They were also not sufficiently aware of their rights and entitlements, or of the complaints procedures. (Recommendation)

74. Care leavers say that personal advisers provide effective, personalised and bespoke support and guidance to enable care leavers to secure further or higher education, employment or training. At 48% in 2015−16, the proportion of care leavers aged 16−18 years who were NEET was, however, too high and the proportion of those aged 19 years was worse. The local authority recognises this issue and has agreed the appointment of two new specialist personal adviser posts, aimed at supporting care leavers into education, employment or training. Processes, such as virtual school staff ensuring that PEP meetings focus sharply on securing the right post-16 destinations, and allocating a designated tutor in a college to support a young person's initial period in further education, are having a positive impact. As it stands, however, the support to young care leavers to ensure that they have a secure and sustained apprenticeship, job or further education place requires improvement. (Recommendation)

75. A local authority-driven 2015–18 NEET strategy is in place, aimed at tackling the 'stubborn challenge' faced in respect of vulnerable groups, including children in care, young offenders and teenage parents. To a large extent, the document rehearses the current situation. It usefully identifies key actions including, for example, supporting schools to provide more responsive information, advice and guidance. However, the strategy is neither sufficiently specific nor far reaching and is premised largely on existing structures and existing contractual arrangements, and so has not yet evidenced a positive impact. (Recommendation)

76. The provision of suitable accommodation has improved over the last year and reflects good liaison with the authority's placement service, district councils and a specialist housing charity. There have been particular improvements in securing supported housing and semi-independence flats. Providers work well to enable care leavers to move beyond these transitional arrangements into long-term stable accommodation or social housing. Some care leavers are benefiting from being able to 'stay put' with their established carers post-18, although overall numbers of care leavers who do this are low. Bed and breakfast accommodation is not used except in exceptional circumstances and unless authorised by a senior manager. All care leavers spoken to feel safe in their respective accommodation.

77. Managers and staff are committed to promoting care leavers' voice and have in place a good range of activities to draw them together for consultation or leisure purposes. The Supporting Young People after Care group meets quarterly and has contributed to service development issues, such as trialling a revised PEP model and interviewing applicants for senior staff roles. Care leavers spoke highly of the celebration and achievement events that the service arranges. Too low a proportion of care leavers, however, access these valuable activities.

Leadership, management and governance	Requires improvement

Summary

Senior managers, political leaders and partner agencies have a clear focus on and prioritisation of children's services in Leicestershire, with a shared ambition to improve outcomes for children, underpinned by effective strategic alignment.

Performance management information and a creative quality assurance and improvement framework have underpinned a good understanding of service quality in many areas, with priorities for improvement identified. However, some processes and data quality issues have led to gaps in information, which have left senior managers unaware of delays in visiting children within the First Response Service and of the extent of the deficiencies in management oversight of practice and supervision. Although it was understood that caseloads for too many staff remain too high, plans to address this have only been partially enacted.

Commissioning practice is supported by detailed needs analysis, giving the authority a clear understanding of its sufficiency requirements, and the majority of placements seen at inspection were of high quality, with effective monitoring arrangements in place.

The authority has an impressive strategic and operational commitment to hearing the voice of and supporting the participation of children and young people, as well as consulting and gaining feedback from a range of service users through a variety of creative engagement methods.

A well-managed project to embed an evidence-based model of child-centred practice is widely used across the authority, but further work is required to ensure its consistent and effective application.

Workforce development, with a range of training opportunities, is valued by workers in the authority, but there is insufficient oversight of the ASYE programme. Development opportunities for more experienced staff and training and development packages for senior practitioners and first-line managers are not sufficiently developed.

Strong strategic arrangements to safeguard children and young people who are at risk of sexual exploitation ensure that children and young people identified as being at risk receive a swift and timely operational response. Further work is required to improve the quality and analysis of return home interviews conducted when children have been missing.

Inspection findings

78. There has been progress made against the majority of recommendations arising from the Safeguarding and Looked After Children inspection of 2012. The strategic focus on early help and prevention in Leicestershire, in particular the Supporting Leicestershire Families (SLF) work, has underpinned the increased capacity and the evaluation of the effectiveness of early help services. Improvements have also been seen in performance management and quality assurance work, the use of advocacy for children in participating in child protection conferences, and the multi-agency contributions to and effectiveness of MARAC. Many of the strengths identified during that inspection remain evident, with effective partnership working and a strong focus on gaining the views of children, parents and carers.

79. Insufficient progress has been made in a small number of critical areas, with the variable quality of assessments and chronologies remaining an issue identified at this inspection. The application of thresholds continues to be an area for improvement, with a particular focus on inconsistent threshold application for cases progressing from section 47 enquires to initial child protection conference. The quality and effectiveness of management oversight and supervision have deteriorated since the previous inspection. (Recommendation)

80. There is clear political focus on children's services in Leicestershire. The committed and experienced lead member has a clear focus on improving outcomes for children and there is regular member oversight and challenge through the children and families overview and scrutiny panel. Children's services have received additional funding to support progress and improvement in the context of the council needing to make overall savings. This has ensured improvements in early help services, through the SLF work stream, in the sufficiency and quality of placements and in the timeliness of health assessments for children looked after. The recently appointed interim DCS and assistant director for social care have strengthened the local authority's improvement plan. Though this identifies clear areas for focus it is not yet sufficiently comprehensive.

81. A clear performance cycle has been established by the local authority, and this is underpinned by a quality assurance and improvement framework that has utilised creative approaches to driving continuous improvement and developing a learning culture across the services. These approaches include the use of practice summits, annual conversations involving senior managers and front-line staff and appreciative inquiries. The audit process is well structured and based on the practice framework used by the authority and appropriately involves service users and front-line practitioners. The capacity to deliver this work is supported by dedicated quality assurance posts.

Learning from complaints is used to inform practice improvements and feeds into the training programme. Although this approach to performance management has supported the local authority to analyse performance and drive improvement in certain areas, this inspection has identified other areas where the improvement required, for example in the First Response service, had not been identified or the required improvement, for example reducing case load size, had not been sufficiently progressed. (Recommendation)

82. In the First Response Service, a lack of appropriate processes has meant that accurate performance information relating to contacts, referrals and assessments has not been available, which has resulted in senior managers not having a reliable picture of current service demands and effectiveness. The high workloads of workers in this service were not fully recognised, as this was not accurately recorded. Management oversight has not been effective in avoiding drift and delay for too many children. The local authority responded swiftly and effectively to the inspection findings in relation to the First Response Service, with immediate action taken to ensure children's safety and well-being, the establishment of a detailed action plan and an increase in staff resourcing to support improvement. (Recommendation)

83. Management oversight of practice and supervision has not consistently focused on the planning and direction of casework, to ensure that work is progressed and decision-making is timely. Workers generally feel that managers are available and supportive, but the frequency and quality of case supervision is not sufficiently rigorous, does not meet the standards set in the supervision policy and results in the support to children and families not being consistently timely or effective. This area for improvement is known to senior managers, but the development plans that are in place have not had sufficient impact at the time of the inspection. (Recommendation)

84. The local authority has recognised that caseloads for too many staff remain too high to support consistent good-quality work with children and families, and it has recently developed a more sophisticated understanding of individual caseload pressures with associated actions to mitigate these. However, further work is required to ensure that manageable caseloads are in place across all services, and this will be facilitated by the recently agreed increase in social work capacity. (Recommendation)

85. Constructive working relationships between strategic leaders across the partnership are evident in Leicestershire. In the local authority, there is a coordinated approach to strategic developments between children's and adult services, with one example being planned joint workforce development in relation to safeguarding and domestic abuse, substance misuse and mental health. This is also reflected in joint approaches between the adult and children's safeguarding boards, which provide regular opportunities for members of these boards to meet together and support shared knowledge and a shared agenda.

86. Strategic partnership priorities are clearly aligned, with partnership roles and responsibilities appropriately identified in the respective strategies. The very recent reinstatement of a children's partnership is aimed at further strengthening the coordination and oversight of partnership work. The joint strategic needs analysis (JSNA) comprehensively considers a range of information and evidence in its analysis of factors that have an impact on the health of the population in Leicestershire, from birth to old age. Children are fully considered, and both universal and needs arising from vulnerability are identified with clear recommendations for action. There is a comprehensive five-year plan to transform mental health and well-being services for children and young people. While some improvements have been noted in the overall waiting times for CAMHS services in the first year of the plan, the inspection has found that children who are looked after continue to wait for unacceptably long periods of time.

87. Increased leadership focus on and the development of commissioning activity over the last year, with a dedicated team supporting the work, has meant that a legacy of poor commissioning practice has been addressed and current practice is responsive and compliant. Leicestershire is part of a regional placement commissioning framework, and the authority has a good understanding of its placement needs. The detailed and responsive needs analysis is supported by the use of a business analyst, which underpins placement planning and commissioning effectively. Close working relationships between social work and commissioners have also supported improved need identification, better placement matching and improved contract monitoring. This has had a substantial and positive impact on the authority's ability to meet its sufficiency duty, and the majority of placements seen at this inspection were of a high quality.

88. The authority has an impressive strategic and operational commitment to hearing the voice of and supporting the participation of children and young people and to consulting and gaining feedback from a range of service users. The Voice approach coordinates, oversees and develops a range of creative initiatives, including pop-up events and a Voice festival, and these link to the quality assurance and improvement work. Through the Voice work, a range of tools has been developed to support front-line practitioners to engage with children and young people. The voice and views of children and young people have been evident in the vast majority of cases seen on this inspection.

89. There are two well-established CiCCs for older and younger children looked after, and these oversee a range of participation activities. Members of the CiCCs have been involved in recruitment activity with regard to both staff and foster carers, and their views have led to improvement in the support available to children looked after by the out-of-hours service. There is also a group for care leavers supporting young people after care (SYPAC), and this has influenced the way in which payments are made to care leavers, to

ensure that they are not left unfunded over bank holidays. The Youth Council has led the Don't Hate – Escalate project, focusing on raising awareness of hate crime among young people. The children's rights service supports the participation of children and young people effectively, both individually and in groups. Children who wish to make a complaint are supported by children's rights officers, and this helps to effect informal resolutions.

90. The corporate parenting board integrates this participative approach, with members of the CiCC co-chairing the board with the lead member, as well as having representatives on the board. This is an active board, with wide-ranging membership, to ensure partnership commitment to the corporate parenting agenda, and meeting minutes evidence coverage and challenge of relevant and key topics for children in care. The co-chairs acknowledged that the board needs to give greater priority to ensuring that appropriate mental health support is available for children looked after.

91. A well-managed project to embed an evidence-based practice framework is delivered as part of the national innovations fund. Cases offered as good practice examples demonstrate that, when used effectively, this approach 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 and young people. Further development is required to ensure consistent application of the framework.

92. There are constructive working relationships between the judiciary, Cafcass and the local authority. Regular meetings between senior managers and the judge and participation in local family justice board meetings and the LSCB sub-group enable trends, challenges and most practice issues to be well understood and addressed. However, a small number of cases seen at the inspection suggest that the local authority may not always be appropriately challenging of court and Cafcass practice. There is a reported improvement in the timeliness of issuing care proceedings and the reasons for cases extending 26 weeks are well understood. Cafcass and Leicestershire are currently developing the implementation of the Cafcass Plus scheme, through which Cafcass becomes involved at the pre-proceedings stage with unborn children whose mothers have previously had children removed.

93. The local authority benefits from a stable workforce with low numbers of agency staff. A workforce strategy is in place for the local authority and a range of learning approaches are utilised. Most staff spoken to at inspection were positive about the availability and quality of training opportunities. The local authority has good links with a number of local universities, which they utilise, for example for student placements and involvement in research.

94. There is no monitoring of the ASYE programme implementation by senior managers and, at this inspection, it was identified that some newly qualified social workers do not have sufficiently regular supervision, and a small

minority do not have protected caseloads. There is no progression route for social workers once they have achieved the ASYE programme. Nor are there any post-qualifying opportunities beyond the practice educator role. There is not a comprehensive training and development package in place for senior practitioners and first-line managers, and this does not promote sound professional or managerial development. (Recommendation)

95. Effective arrangements to address the needs of young people at risk of child sexual exploitation are in place with the primary delivery mechanism, through a multi-agency child sexual exploitation hub that is currently working with over 40 young people. There are clear governance and reporting structures that underpin the delivery of the multi-agency strategy and action plan. There is strong partnership commitment to resourcing the work, which is supporting the development of creative approaches regionally. Much has been done to promote awareness of child sexual exploitation and trafficking, and there is evidence of this having an impact in terms of notifications. One example of a range of preventative approaches is a locally developed DVD relating to the grooming and murder of a local child, which has been used to good effect in raising awareness of the dangers of online grooming. This has been seen by 28,000 children and resulted in 32 direct disclosures and one perpetrator charged. The links to missing children about the risk of child sexual exploitation are well understood, but the quality of return home interviews, particularly for children who are looked after, does not consistently analyse or recommend actions to ensure the child's safety, and the strategic analysis from the data of those interviews is not sufficiently developed. The local authority acknowledges that further work is required to gain a clear overview of prevalence and patterns, regarding children missing from home or care, and work is in progress to ensure a robust dataset.

96. The 'Prevent' duty work and agenda are embedded and continuing to develop in Leicestershire. There is clear strategic governance, and creative operational work is being undertaken to raise awareness and identify and respond to risks. There is a good understanding of the nature of potential extremism in the area, and effective individual work with young people is described.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is good

Executive summary

This Local Safeguarding Children Board in Leicestershire is joint with Rutland. It is well run and effective. Visible leadership by the chair and the engagement of leaders across the partnership are helping to keep safeguarding high on the agenda in the county. The board has developed an ethos of constructive challenge and support. It has taken a thoughtful and flexible approach, sensibly working closely with the Safeguarding Adults Board and Leicester City LSCB in areas of common concern.

Drawing on a comprehensive multi-agency dataset, regular thematic audits and learning from case reviews, it has established an authoritative evaluation of the effectiveness of safeguarding, focusing clearly on the needs of children in both local authority areas. Its section 11 audits are not sufficiently probing.

The board's scrutiny and influence have a positive impact on front-line practice, facilitating better understanding of the threshold into children's social care, more timely identification of the health needs of children looked after and the improving response, which inspectors have seen when children are at risk of sexual exploitation. It regularly monitors completion rates for return home interviews for children going missing, although its analysis of the impact of this process is limited.

The board has initiated SCRs appropriately, not waiting for publication to take action to promote improvement. Its child death overview process is highly effective. A comprehensive analysis of long-term patterns enables the board to influence wider health priorities and to promote initiatives, which are improving children's safety.

The board has developed a comprehensive approach to evaluating safeguarding training, demonstrating a positive and sustained impact for practitioners. Its scrutiny and challenge have not been sufficient to halt an increase in withdrawals from booked places on training courses, although it is using other ways to reach out to front-line professionals.

The LSCB has rightly emphasised the importance of children's participation in the work of the member agencies. There are ad hoc examples of the board and partners reaching out to children. However, children are not directly influencing the board's own direction and priorities.

Recommendations

97. Ensure that the quality and effectiveness of return home interviews and risk management when children are going missing from home or care are evaluated.

98. Review the section 11 audit process, to ensure that these audits are sufficiently probing and robust.

99. Enable children to influence the LSCB's priorities and their delivery more fully.

Inspection findings – the Local Safeguarding Children Board

100. The Leicestershire and Rutland LSCB is effective and well run. Responsive and proactive leadership from the independent chair is keeping safeguarding high on the agenda in the county. The board has successfully engaged statutory partners, and proactively reached out to voluntary and community organisations, to identify their safeguarding awareness and needs. The board works closely with the Leicester City LSCB in areas of common concern, such as child death, safeguarding procedures and multi-agency training. The Safeguarding Adult Board is similarly joint with Rutland and has the same chair as the children's board. This has enabled the establishment of joint strategic priorities, relating to mental health, domestic abuse and the 'Prevent' duty. The board structure is efficient and streamlined. Both boards are supported by the same business unit, which helps to ensure appropriate alignment and information sharing. The business unit also ensures that each of the strategic lead officers for the board's six priorities, as well as its three joint priorities with the adult board, receives an effective support service, to facilitate delivery of the annually refreshed business plan.

101. The chair brings an extensive knowledge base, helping members to ask questions and challenge each other while maintaining constructive working relationships. Board members regularly scrutinise monitoring reports, assessing improvement and challenging each other when performance is not good enough. Lay members are supported well, and this has made them feel confident about asking questions and challenging the professionals around the table. The escalation process is being used, and the independent chair is proactive in challenging partners when improvements are needed. The LSCB sets priorities and targets for improvement and has a clear auditing and monitoring process, to assess whether these are met.

102. While the local authority is set to reduce its financial contribution to the LSCB in 2017–18, it provides a considerable contribution in kind, including case file auditing, SCRs and meeting facilities. Other statutory partners have confirmed their contribution at the same rate as that of the current year.

103. The board uses a wide range of intelligence to inform and adjust its priorities, drawing on regular audit and quality assurance activity, an extensive multi-agency dataset and practitioners' views. The board has used its audit findings and performance data well, to influence and challenge other strategic partnerships in their priority setting, for example prompting discussions about early help and thresholds at the local authority's scrutiny committee. Multi-agency audits are well planned, regular and delivered on time. The themes chosen link clearly to the LSCB's business priorities and learning from SCRs. They direct attention to aspects of help and protection, such as thresholds and child protection plans, in which the local authority inspection findings demonstrate the need for scrutiny. Audit findings inform practice guidance and training for practitioners, with a focus in the last year on disguised compliance, a neglect toolkit and effective supervision. The board has closely scrutinised the higher number of children who have repeat child protection plans in Leicestershire, compared to the national average. Through commissioning multi-agency audits and drawing on the local authority's audits, it has evaluated practice in this area and highlighted the need for the authority to strengthen oversight and decision-making when professionals are considering stepping children's cases down from child protection plans. It clearly identifies this as a priority for further improvement.

104. Rather than commissioning a multi-agency audit of early help work, the board has scrutinised practice through a joint report from the two local authorities and monitors a wide range of relevant measures in the multi-agency dataset. It has focused multi-agency auditing in this area on the experience of children for whom intervention is stepping up and stepping down between early help and children's social care. This selective approach makes sense, given inspectors' positive findings about early help in the local authority inspection.

105. Section 11 audits are not sufficiently probing. While the LSCB uses a wide range of other intelligence to evaluate the quality of help and protection, and does not rely solely on these audits, there is a mismatch between the high level of compliance with standards, as reported by member agencies in their section 11 returns, and the more comprehensive and accurate picture of practice revealed when all of the board's audit and scrutiny activities are taken into account. (Recommendation)

106. The board has begun to evaluate safeguarding practice in relation to disabled children, analysing data and preparing an audit tool ready for a multi-agency audit in 2017–18. Effective scrutiny and challenge by the LSCB has also helped to ensure that the physical health needs of children looked after are identified and addressed more quickly.

107. The LSCB is identifying learning effectively from SCRs. Reviews are undertaken and published when the criteria are met. Decisions to delay the recent publication of reports from serious cases from 2012 and 2014, pending completion of criminal investigations, were appropriate. The board provides

regular learning events and bulletins to highlight lessons from audits and SCRs. Attendance at these learning events has been generally good and includes professionals from both statutory and independent services.

108. Member agencies have not waited for publication to act on lessons emerging from SCRs. For example, in response to the recent child-murder case, a powerful 'Kayleigh's love story' film is being used proactively by police officers; social workers and schools to warn children of the dangers of online grooming. This work has led directly to disclosures from children who have come forward to seek help and to the prosecution of an offender.

109. The LSCB regularly reviews its multi-agency safeguarding procedures, refining these in response to local and national developments. This work is undertaken jointly with Leicester City LSCB – an example of joint working arrangements, which both independent chairs have keenly promoted. Recent examples include strengthening guidance on bruising in pre-mobile babies, in the light of SCR findings, and updating the threshold document to cover breast ironing, in response to emerging awareness of this issue.

110. The board has updated its procedures on female genital mutilation and has implemented a communication plan, with a YouTube video and engagement activities with the Somali community. There is an annual awareness raising campaign, undertaken jointly with Leicester City, prior to the summer holidays. This includes dissemination of the board leaflet; procedures; website link and the video, all of which are sent to every school in the three local authority areas. These activities have successfully helped to raise awareness, with the first Leicestershire children being referred to the police.

111. The board has facilitated an increasingly comprehensive approach to safeguarding children at risk of sexual exploitation, reflected in the well-structured multi-agency work that inspectors found in both local authority inspections. It has exercised repeated scrutiny and challenge in relation to practice here. The independent chair is proactively holding agencies to account and monitoring the establishment of the multi-agency specialist child sexual exploitation hub. A data analyst is bringing together information on hotspots and profiles of offenders and victims. Training and guidance have been informed by regular multi-agency auditing, with a further audit at the time of the inspection.

112. Analysis of LSCB multi-agency data indicates a positive impact on professionals' awareness and understanding of child sexual exploitation, and there has been a sustained increase in the last year in child sexual exploitation-related referrals to children's social care. Professionals are also making greater use of a risk assessment toolkit, which has been introduced to improve protection for children at risk of child sexual exploitation.

113. The board monitors completion rates for return home interviews with children who go missing and has raised with the local authority the gap between numbers of missing episodes and completed interviews. Qualitative findings, focusing on how effectively this process is reducing risk, are more limited. This is a significant gap, given the issues identified in the local authority inspection regarding return interviews for children looked after. (Recommendation)

114. The board is honest and open in its analysis about areas where its scrutiny and challenge have not had the desired impact. In particular, numbers of cases being identified in which children are living in private fostering arrangements have remained stubbornly low, despite regular scrutiny through the board's quarterly performance data reports. The local authority has recognised the need to do more in this area.

115. The child death overview panel is highly effective. Careful analysis of findings over the longer term has enabled the panel to identify patterns that might otherwise be missed. It uses this intelligence well to raise awareness of safety risks for children, inform improvements and influence wider health and well-being priorities. This is a particularly strong element of the LSCB's work.

116. The board has put in place a sophisticated approach to evaluating the impact of safeguarding training. This is also a significant strength. Post-training survey data shows a consistent picture of safeguarding training having a sustained impact on trainees' skills, knowledge and confidence. The training offer links clearly to LSCB priorities, reflecting themes from SCRs and audit activity. As an increasing number of professionals are withdrawing from booked places during 2016-17 the board is robustly highlighting this issue with the member agencies and is maintaining a charging policy to discourage withdrawals.

117. It is also using a range of other means to provide information on safeguarding to professionals. A very informative 'Safeguarding matters' newsletter highlights learning from case reviews and audits and provides practical guidance to promote improvement. Designated nurses have provided some targeted input for Leicestershire schools, through local special educational needs coordinator (SENCo) networks. Voluntary sector representatives are promoting training to local voluntary sector and community organisations.

118. The LSCB has rightly emphasised the importance of children's participation in the work of the member agencies. The board has agreed to make this an integral feature across the work programme, although business plan progress reports do not demonstrate that this is happening consistently, and a subgroup, established specifically to promote children's influence, proved unsuccessful. There are examples of the board and partners reaching out to children. For example, the chair meets the youth councils and CiCCs in both

local authority areas. However, children are not directly influencing the LSCB's overall direction and priorities. (Recommendation)

119. The board's annual report provides a comprehensive evaluation of the effectiveness of safeguarding. Importantly for an LSCB covering two local authority areas, it provides distinct findings about practice and performance in both Leicestershire and Rutland. It assesses the impact of improvements that the board and member agencies are making, and improving conversion of contacts to referrals to children's social care indicate a better understanding of thresholds.

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 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 that 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 whom it is trying to help, protect and look after.

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

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

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

The inspection team consisted of seven of Her Majesty's Inspectors (HMI), two senior HMI and one Social Care Regulatory Inspector (SCRI) from Ofsted.

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