Leicester City

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 January – 4 February 2015

Report published: 20 March 2015

The overall judgement is that children's services are inadequate
There are widespread or serious failures that create or leave children being harmed or at risk of harm. Leaders and managers have not been able to demonstrate sufficient understanding of failures and have been ineffective in prioritising, challenging and making improvements. It is Ofsted's expectation that, as a minimum, all children and young people receive good help, care and protection.[2]

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

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

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

Contents

The Local Authority

Summary of findings

Children's services in Leicester City are inadequate because:

Leadership and management

- There has been a corporate failure of leadership, which has resulted in services deteriorating to a point where children are not adequately protected. The current Director of Children's Services (DCS) has only been in post since October 2014 and the positive impact of this appointment is only just beginning to be felt.
- Failure to manage wholescale organisational change effectively in children's services from May 2014 has led to a high turnover of social workers and managers. This has resulted in unacceptable delays in the allocation of children's cases, frequent changes of social worker and in poor quality management oversight and direction.
- Serious and wide-scale failures in seeing and assessing children in a timely manner have resulted in children potentially remaining in harmful and unsafe situations, at risk of neglect and emotional abuse.
- Performance data and its reporting are poor. Leaders and managers at all levels do not have the information they need to manage effectively.
- While the local authority and its partners are well engaged in the key strategic boards, this is not significantly influencing frontline practice.

Quality of practice

- Social work practice is not robust, and in too many cases, assessments and plans are not of good enough quality.
- Changes of social workers and managers means that plans to reduce harm have been subject to drift and delay.
- Weak management oversight leaves poor practice unchallenged and children's needs unmet.
- The social work electronic recording system is under-developed both as a practice tool and as a data gathering and reporting mechanism.
- Practitioners are insufficiently aware of the indicators of child sexual exploitation to ensure early identification and social workers are not appropriately completing return interviews when children known to them go missing.

What does the Local Authority need to improve?

Priority and immediate action

Leadership and management

1. Put into place an effective performance management framework; this to include
    - comprehensive and reliable performance data
    - clear monitoring and quality assurance arrangements
    - effective performance management of teams and individuals.
2. Ensure that all staff receive regular reflective supervision, in line with the local authority's supervision policy, that provides direction and includes consideration of the individual's developmental needs and professional capability.
3. Ensure that suitable arrangements are in place to support and meet the needs of 16- and 17-year-olds who become homeless.

Quality of practice

4. Improve the quality and consistency of assessments so that risks and concerns are robustly considered and inform plans about what needs to change.
5. Improve the continuity of social worker for children and young people and ensure the timeliness and consistency of social work home visits.
6. Improve the quality and delivery of plans to meet the needs of children and ensure that they are not subject to drift or delay.

Areas for improvement

Leadership and management

7. Ensure effective oversight and examination of data and practice by the Scrutiny Commission and the Corporate Parenting Forum.
8. Ensure the local authority's full engagement with Cafcass and the Family Courts and improve the quality of pre-proceedings and court work.
9. With partners, ensure that professionals are fully aware of their role in contributing to the identification and support of children with additional needs, and where appropriate assist them to access early help services.
10. Ensure that the electronic social care recording system promotes good practice, supports managerial oversight and provides accurate performance information.

Quality of practice

11. Improve the timeliness of social work interventions and ensure effective permanence planning, including the consideration of all permanence options, within the child's timescales.

12. Improve the consistency and quality of case recording and chronologies and ensure that scanned documentation and key documents, such as looked after review outcomes, are more certainly and swiftly available on the electronic social care recording system.

13. Ensure that practitioners are aware of the indicators of child sexual exploitation so that risk is identified early and preventative measures can be put into place.

14. Ensure that when a child, in receipt of a social work service, goes missing from home or care, a return visit is completed promptly, that the outcome is appropriately recorded and that it informs the child's plan and local intelligence gathering.

Children looked after

15. Ensure that care plans are informed by regular and up-to-date assessments of needs.

16. Ensure that initial health assessments for children looked after take place within 28 days of their reception into care.

17. Improve the consistency and quality of personal education plans as a tool to improve the educational attainment and achievement of children looked after.

18. Ensure that effective re-unification plans are agreed by a statutory review and that these arrangements are monitored in a timely way following the child's return home.

19. Strengthen the capacity of the Independent Reviewing Officer (IRO) service to fulfil all aspects of the IRO Handbook, particularly enabling them to more effectively track and quality assure the progress of care plans in between statutory review processes.

20. Improve the timeliness and quality of foster carer reviews and strengthen the level of independent oversight provided within reviews.

Care leavers

21. Ensure that caseloads are at a level that enables personal advisors to work proactively with all care leavers allocated to them, including those aged 16 and 17 years.

22. Strengthen the pathway review process to ensure that formal reviews take place regularly with the contribution of other agencies and are subject to robust management oversight.

23. Ensure that risk assessments are undertaken for all young people living in unsuitable accommodation.

24. Ensure that care leavers are provided with full information about their health histories prior to leaving care.

The Local Authority's strengths

25. The local authority has established an efficient and well-organised 24/7 duty and advice service that provides good quality information and appropriately refers children to early help or social care services. Children in need of protection are effectively responded to out of hours.

26. Disabled children are well supported by specialist staff and have voice and influence through the Big Mouth and Little Mouth fora.

27. Appropriate attention is paid to diversity, and the Heritage Panel plays a key role in ensuring that heritage needs of children and young people are addressed in all aspects of service delivery.

28. There is detailed sharing of information and local intelligence about children thought to be at risk of child sexual exploitation that is used to produce detailed multi-agency plans. Young people engage in the meetings, which consider these plans.

29. The Local Authority Designated Officer (LADO) has ensured that sound arrangements are in place to respond to cases when allegations are made about professionals who work with children.

30. Though 47% of children looked after are placed outside of Leicester City, 87% live within 20 miles of their home. The majority of young people placed out of authority are not disadvantaged by distance and have appropriate access to health and education services.

31. 79% of children looked after are placed with foster carers, higher than statistical neighbours and England levels. Appropriate use is also made of kinship placements, which enable children to remain with their families and communities.

32. Children looked after have good access to therapeutic help and recreational leisure opportunities, which promotes their health and well-being.

33. Children with an adoption plan are quickly matched and placed with adopters, maximising their life chances in their adoptive homes.

34. Post-adoption support is a significant strength, evidenced by the value placed on it by adopters and the lack of adoption disruptions.

35. Through the Big Lottery funded Y-POD, care leavers with complex needs have been provided with wraparound services which improves their outcomes. These benefits are planned to be rolled out to all care leavers in April 2015.

Progress since the last inspection

36. The previous permanent DCS left the authority in May 2013. The new and current DCS joined the authority in October 2014 and in the intervening period interim leadership arrangements were in place. The current DCS and interim Assistant Director (AD) have quickly grasped and begun to tackle some of the critical issues around staffing and performance information. Their efforts however, remain hampered by the poor quality of current performance data and difficulties in establishing clear sight of the current quality of front line services. The local authority's performance has deteriorated significantly in a number of areas since it was last inspected.

37. The previous inspection of Leicester City's children's safeguarding services was in December 2011. The local authority was judged to be adequate.

38. Some of the areas for improvement identified in that inspection are still areas requiring improvement. This includes the failure of some professionals in universal services to engage with the local authority's early help offer, improving the quality of management oversight and improving the quality and delivery of child protection plans.

39. LADO arrangements are now operating effectively.

40. Some of the strengths identified at that inspection, such as the sufficiency and stability of the workforce and the good quality performance information and monitoring of progress, have significantly deteriorated and this is now adversely affecting outcomes for children.

41. The previous inspection of Leicester City's services for children looked after was in December 2011. The local authority was judged to be good.

42. Some of the strengths identified at that inspection have not been maintained, such as the timeliness of health assessments, continuity of social worker, the numbers of care leavers in education, employment or training and the effectiveness of the IRO service. Children currently looked after particularly express their concern about changes in social worker.

43. The local authority has changed its infrastructure supporting the work of children's services staff. In May 2014, a reorganisation took place, which aimed to strengthen how social care and early help services were arranged and delivered across the city.

44. Through the innovative Y project, the local authority has supported a diverse community organisation that seeks to empower young people to achieve skills and independence through access to supported accommodation, education, arts, health and fitness.

Summary for children and young people

- Social workers always try to assist children and their families but sometimes they take too long to give them the support that they need. When this happens children and their families can get into more difficulties.
- Some children have had too many social workers in a short time. They told inspectors that this does not help them to get to know their social worker well and it takes new workers time to understand their life story and to get children the right help in the way that they want.
- Managers do not always check the work of their teams carefully. This is not helpful because when mistakes are made, it stops children and families getting the help they need quickly.
- Children told inspectors that the Children in Care Council works well with local authority officers to make the right changes.
- A new approach to working with families means that staff providing early help services meet and share information well and find helpful actions to deal with the problems that families are experiencing.
- Most children who cannot live with their parents/carers are placed quickly with their extended family or with friends or with adopters, and the local authority makes a lot of effort to keep brothers and sisters together. When adoption takes place, families receive good support which helps the placement to work well.
- Nearly all care leavers live in suitable accommodation and they can choose where to live. Care leavers need guidance on what to do about work or going to college, but the younger adults aged 16 and 17 do not get as much support as those aged over 18 to help them prepare for their future.
- The local authority works well with children and families from different cultural backgrounds and faiths and with different needs. For example, children from minority ethnic groups are matched to adoptive families from similar backgrounds, and children with a disability receive the support and help needed to protect them.

Information about this Local Authority area[3]

Children living in this area

- Approximately 79,000 children and young people under the age of 18 years live in Leicester City. This is 24% of the total population in the area.
- Approximately 30% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 22% (the national average is 17%)
  - in secondary schools is 22% (the national average is 15%).
- Children and young people from minority ethnic groups account for 59% 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 and Asian mixed and Black or Black British.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 49% (the national average is 19%)
  - in secondary schools is 46% (the national average is 14%).

Child protection in this area

- At 31 December 2014, 2,150 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 1,920 at 31 March 2014.
- At 31 December 2014, 349 children and young people were the subject of a child protection plan. This is an increase from 326 at 31 March 2014.
- At 31 December 2014, three children lived in a privately arranged fostering placement. This is a reduction from seven at 31 March 2014.

Children looked after in this area

- At December 2014, 549 children were being looked after by the local authority (a rate of 69 per 10,000 children). This is an increase from 530 (67 per 10,000 children) at 31 March 2014. Of this number:
  - 267 (or 47%) live outside the local authority area

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

- 55 live in residential children's homes, of whom 36% live out of the authority area
- seven live in residential special schools[4], of whom 100% live out of the authority area
- 426 live with foster families, of whom 45% live out of the authority area
- 25 live with parents, of whom 35% live out of the authority area
- eight children are unaccompanied asylum-seeking children.

- In the last 12 months:
  - there have been 42 adoptions
  - 31 children became subjects of special guardianship orders
  - 136 children ceased to be looked after, of whom 7.4% subsequently returned to be looked after
  - 103 children and young people ceased to be looked after and moved on to independent living
  - four children and young people ceased to be looked after and are now living in houses of multiple occupation.

Other Ofsted inspections

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

Other information about this area

- The Director of Children's Services has been in post since October 2014.
- The Chair of the LSCB has been in post since December 2012.

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

Inspection judgements about the Local Authority

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

Summary

Too many children have experienced delay because of numerous changes of social worker or because they have not had a social worker allocated to them in a timely manner. As a result, children remain in potentially harmful and unsafe situations, at risk of neglect and emotional abuse for too long before plans are put in place to reduce the harm they may experience. Weak and inconsistent management oversight leaves poor practice unchallenged and children's needs unmet.

The quality of assessments is too variable and many do not have a sufficient analysis of risk to inform effective planning for children. The majority of chronologies are system-generated and do not tell the child's story, and so a child's history is not used effectively to inform assessments. Social workers visit children, but not as frequently as stated in plans; when they do visit, almost all social workers are making efforts to speak with children alone and secure their views. A minority of Initial Child Protection Conferences are not timely, in contrast with the 100% of review meetings, which are held on time. The high turnover in social workers has affected the frequency of core group meetings and contributes to the drift and delay in implementing child protection plans.

Many children known to children's services do not benefit from return interviews when they go missing. As a result, plans to reduce further missing episodes and tackle risks of missing are not in place. When young people are known to be at risk of child sexual exploitation, robust multi-agency action occurs to reduce these risks. However, for other young people, opportunities are missed or intervention does not happen when potential risks are first identified, and concerns escalate.

Children and their families benefit from the support provided by the early help teams. The local authority drives early help work, and not all partners fully understand or contribute to the local early help offer. Partners continue to make inappropriate referrals to children's services and do not fully understand local threshold arrangements and levels of intervention. The lack of a joint working protocol with Housing means that there is no clear arrangement in place to appropriately assess the needs of 16- and 17-year-old homeless young people.

Disabled children are well supported by staff in a specialist service and effective plans are put into place, which are routinely monitored by managers. Parents of children with complex health need are particularly appreciative of the support their children receive to facilitate their transition to adult services

45. The local authority Early Help and Prevention Strategy 2013–15 was agreed by the Children's Trust in 2013. It provided for the creation of early help teams based in children's centres in six geographical areas of the city; these were formally established in July 2014. Practitioners from a range of professional backgrounds, including family support, youth work, and early childhood development backgrounds appropriately are part of these teams. Inspectors saw evidence of effective work, which is ensuring that children's needs are met and their circumstances improve.

46. Early help teams receive referrals from universal services when children are identified as needing additional support. Currently, the lack of a strategically co-ordinated approach to the publicity about the early help teams means that referrals are low. In addition, universal services are not clear about their role in early help work. As a result, the numbers of children and families helped through the Common Assessment Framework has reduced. The Children's Trust and the LSCB have not provided sufficient scrutiny of the effectiveness of the early help strategy.

47. In the cases sampled, children and their families benefited from the support provided by the early help teams. The quality of early help assessments is improving. More recent early help assessments clearly identify the difficulties that families are experiencing, and records demonstrate that a range of services are provided to families in a timely manner to meet identified needs. Progress is effectively tracked using a simple scoring system to which parents contribute. Some good examples were seen by inspectors whereby the early help support led to improvements in parenting skills, children's behaviour and their attendance at school. Early help managers provide regular supervision to workers about individual cases. The depth of this management oversight remains inconsistent, with some managers not fully exploring the extent to which the help provided is improving the circumstances for the child.

48. Workers present cases to the monthly Early Help Review Panel when children's circumstances do not improve as a result of the early help support families have received. The panel provides clear direction about next steps, which can include a referral to children's social care for a statutory assessment. Step up and step down arrangements to and from social care are clear and well understood by practitioners.

49. The Duty and Advice Service (DAS) delivers a 24-hour, seven day a week service responding promptly and consistently to all contacts and referrals made to children's services, including those made outside normal office hours. Qualified and experienced social workers provide consultation and sound advice to professionals who are concerned about children.

50. Staff in DAS have a good understanding of thresholds for statutory intervention and apply these consistently. Information sharing between DAS social workers and the DAS early help service is effective. This ensures that children who have identified needs but who do not meet the threshold for a statutory service are signposted to early help services. DAS early help practitioners provide timely short-term interventions and effectively evaluate outcomes achieved. When families require longer-term support, the DAS early help service ensures the prompt transfer to locality early help teams.

51. Children's services continue to receive too many inappropriate referrals from partners. In 2013–14, only 52% of referrals progressed to a single assessment. The local authority's own data for 2014–15 show a slight improvement to 58%, but this is below the local target of 70%; 29.3% of referrals received since April 2014 are re-referrals. In particular, cases referred by the police are not risk assessed, resulting in inappropriate referrals to DAS. Other inappropriate referrals demonstrate that staff in universal services do not fully understand the local threshold document or their contribution to the delivery of early help. There is no systematic analysis of these inappropriate referrals to inform plans to tackle this issue.

52. When children are referred to children's services because they are at risk of immediate harm, DAS takes effective steps to ensure that they are safe. Strategy discussions are promptly held with the police and next steps are well recorded. The involvement of other agencies in strategy discussions is less consistent but does take place in more complex cases. Joint investigations with the police take place routinely. On occasions when DAS agree with the police to undertake investigations as a single agency, the rationale for this decision-making is not well recorded.

53. When children require ongoing intervention by children's services, they are promptly transferred by DAS to Children in Need (CIN) social work teams. In most cases, this decision-making is sound. However, in a small number of cases seen by inspectors, section 47 investigations should have been initiated by DAS before transfer to ensure that children were appropriately protected. Until inspectors identified this, these cases had remained unallocated and children were left experiencing ongoing neglect and emotional harm.

54. In May 2014, children's services were restructured. This resulted in significant staff turnover in all nine CIN teams. Of the 62 social workers in post during the inspection, 22 were temporary agency staff. Many were recent starters replacing other agency staff who only worked with the authority for a short period. This staff disruption has adversely affected the timely allocation of cases, the progress of plans for children, management oversight and continuity of social workers for families.

55. Once the service restructured in May 2014, staff turnover became increasingly problematic and affected the ability of managers to allocate cases promptly. As recently as 17 December 2014, 291 children did not have a social worker. An increase of agency staff reduced this number to 38 by 21 January 2015. Because of this staffing instability, there has been significant delay between the decisions that a single assessment should be undertaken and the children being seen and their needs being fully assessed. Too often, a number of cases were allocated to new workers without management direction and prioritisation or any subsequent review. This built in further delay while social workers became familiar with cases and prioritised their visits to children and their families. In only two of the 33 cases sampled by inspectors were children seen promptly once the case had transferred to the CIN teams. In six of these cases, there was no evidence that the children had been seen prior to inspectors arriving on site, when dates of referral varied from August 2014 to December 2014. Once aware of inspectors' concerns, the local authority took immediate steps to ensure that the children were seen and were safe.

56. The local authority has no systematic management monitoring to confirm the timeliness and the quality of visits to children. Therefore, it cannot establish how long children wait to be visited by a social worker after they are first referred to the service. The authority recognises the need to address this, and during the inspection it started to develop a performance report to provide information about social work visits.

57. These capacity issues have led to direct delays in children having their needs assessed and responded to. The local authority's own data for 2014–15 indicates that around one third of assessments are not completed within their target timescale even though these timescales allows several weeks for the completion of most assessments. This is further compounded by management decisions to delay the allocation of cases where assessments are likely to be less complex. This delay means that these children are waiting too long before their needs start to be assessed.

58. The quality of assessments is too variable. Inspectors saw some high quality, thorough assessments with sound analysis, but many did not have a sufficient analysis of risk to inform effective planning for children. The majority of chronologies are system-generated and do not tell the child's story. A child's history is not used effectively to inform assessments and planning. This contributes to further drift and delay for children because new practitioners repeat interventions that have previously failed to improve their circumstances.

59. Once allocated, children are visited by social workers, but not as frequently as stated in their plans. Almost all social workers are making efforts to speak with children alone. While the quality remains variable, some good examples were seen of discussions with children about their experiences and what they wanted to change. Sustained relationships between children and their worker are not evident in many cases, due to frequent changes in social workers.

60. At 31 December 2014, 349 children were the subject of child protection plans. In the year 2013–14, the most prevalent categories of abuse were neglect (38.4%) and emotional abuse (37.54%). Inspectors found inconsistent use of pre-proceeding processes in these cases to bring about swift improvements for children.

61. The local authority's own data for 2014–15 identifies that only 54.9% of initial child protection conferences are timely which means that for these children there is a delay in decision-making. This is, however, an improving trend from a very low base of 26.4% in 2013–14. In contrast, the timeliness of review child protection case conferences is excellent, with 100% occurring in timescale; this performance has been sustained for more than 18 months. Concerns about some agencies' poor attendance and failure to provide reports has led the Safeguarding Unit to monitor attendance, and senior managers are now appropriately challenging the relevant agencies. This has led to improved attendance by some partners, but is yet to have an impact on others.

62. The turnover in social workers also contributes to delays in the progress of child protection plans. In some cases, core groups are not held routinely, with gaps because of changes in social workers. Most partners routinely attend core group meetings when they do happen, and share information about their involvement with the family. Parents are routinely invited and many do attend. Social workers take the minutes of core group meetings, but the quality of these varies. In particular, they do not always reflect the progress against the child protection plan, whether the plan is making a difference for the child, or if the plan needs to be changed. The electronically generated child protection plan template used does not assist good planning. As a result, plans lack specificity; they are not clear about who is taking action and by when and they do not prioritise the key changes needed. Not all plans are routinely updated following core group meetings. One parent reported to an inspector that the format is confusing, so they pay no regard to it.

63. Child protection chairs also chair initial child in need meetings. This brings improved focus to initial plans and seeks to improve partners' confidence in the child in need planning process. This is a very recent initiative and has yet to be evaluated for impact. Despite this, child in need work reflects many of the same inconsistences as child protection work, due to the instability of the workforce.

64. In total, 25 cases were formally referred back to the local authority as having significant concerns in social work practice that left children with risks and concerns unassessed, needs not met, children not visited and insufficient action taken to ensure that they are safe. Of these, 19 children are held in CIN teams. In addition, a number of other cases were identified as examples of further poor or inconsistent practice that required senior management review. The local authority agreed with the poor practice identified and took appropriate steps in these cases to rectify identified deficits during the inspection.

65. The quality of management oversight is weak. This is in part due to the turnover of managers. While the majority of cases have evidence of some management oversight recorded on file, this is not always at the required frequency and some have extensive gaps. The quality of the direction provided is poor; previous actions are not always reviewed for their completion, and agreed actions routinely lack a timescale for completion. Most significantly, children's plans are not systematically reviewed in supervision to establish if they are reducing risks to children. Often, significant events are not well considered and appropriate plans put in place to respond to increased risks.

66. Despite the existence of a robust procedure, arrangements in CIN teams to undertake return interviews for children and young people who go missing are not well established. Visits, when they do take place, are not always timely nor often recorded as a case note. The agreed template is not used, so consistent information is not gathered over time that can be easily analysed and can contribute to safety planning. Managers do not consider the risks to young people from these missing episodes, nor ensure that plans are in place to reduce future missing episodes.

67. When children are not known to social care services, the early help service will undertake return interviews. These arrangements are recent, but already there is improved confidence in their certainty and quality. Visits to children are not always timely, but findings are reviewed at subsequent meetings, which inform support plans for families. As a result, very recent reductions have been seen in the frequency of missing episodes for some of these children.

68. The weekly multi-agency missing meetings provide a regular arrangement for information sharing and gathering intelligence between agencies about children who are missing from home, care and school. The education welfare service contributes to the information sharing about children's absence during the school day and supports schools to recognise the potential risks related to such absence.

69. This service also keeps a close check on the increasing number of children whose parents select home education as their preferred option. As well as providing support and advice for families, the service undertakes home visits to ensure that these children are safe from harm. It has also been instrumental in taking legal action to return a very small group of children to mainstream school. Partnership work across several services underpins monitoring of the whereabouts of those educated at home.

70. The One pupil data system is used to identify the status of pupils in or out of schools and to track those who do not attend regularly, and information sharing between the education welfare service and other services ensures that investigative work on children new to education in the city runs smoothly. Each early help cluster has an officer with responsibility for attendance and children missing education, and they employ a range of approaches to track such children and young people, beginning with local enquiries in the neighbourhood, contacting a range of local services, and then national services such as the Border Agency.

71. The local authority does not currently have a clear or comprehensive overview of all children receiving alternative educational provision. It is in the process of strengthening its arrangements to monitor the quality and take up of this provision. It has undertaken some effective project work with Gypsy, Roma and Traveller communities, which has significantly improved the school attendance of children from these communities.

72. When young people are at high risk of experiencing child sexual exploitation, multi-agency meetings are held and are well attended by professionals. Effective sharing of information and local intelligence is used to produce detailed multi-agency protection plans that are regularly reviewed and work well to reduce risks to young people. Attendance by young people at these meetings is a strength. Currently, 21 young people are subject to these regular meetings, of whom 11 are children looked after. A further four young people have an initial meeting planned in February 2015. Young people involved in child sexual exploitation are offered therapeutic support by the Child and Family Support Team.

73. The high turnover in staff means that many social workers and managers have not received training to enable them to identify early signs of potential child sexual exploitation. A specialist child sexual exploitation worker is available to provide advice to workers when they are concerned. This worker encourages the completion of child sexual exploitation risk assessment tools, but oversight to ensure their completion does not routinely occur. In some cases, inspectors saw delays in identifying the extent of the risk of child sexual exploitation and opportunities missed to intervene earlier. Managers accept that further work is needed to ensure a robust response to the identification of child sexual exploitation in cases held in CIN teams where this is not an obvious presenting issue upon referral.

74. The housing protocol does not describe a joint process for assessing 16- and 17-year-old young people who become homeless. The local authority has looked after five of the 49 young people presenting to homeless services in 2014–15 to date. However, the authority cannot identify whether those young people who do not become looked after are provided with appropriate support as children in need and have effective plans in place to meet those needs.

75. The Disabled Children's Service appropriately identifies when children are at risk and takes appropriate steps to protect them. Ongoing work with families supports the identification of concerns early. Proactive steps are taken to tackle and reduce these concerns. Consistent management oversight is provided that ensures the timely progression of plans for children.

76. Sound arrangements are in place to respond to cases when allegations are made about professionals who work with children. The interim LADO is relatively new to this post and has yet to develop robust monitoring systems to quality assure the decisions taken by those who undertake work within the team.

77. Regular Multi-Agency Risk Assessment Conference (MARAC) meetings take place, which ensures timely sharing of information between professionals about those people at high risk of domestic abuse. Referrals from partners other than the police to MARAC is 43%, which is good performance and better than the Co-ordinated Action Against Domestic Abuse (CAADA) target of 25-40%. This demonstrates the commitment of partners to supporting victims of domestic abuse. A wide range of initiatives are in place to support families where domestic abuse is a concern, including programmes for perpetrators. The Freedom Programme is routinely delivered to support victims of domestic abuse, and interpreters are provided where necessary. The draft Domestic Violence Strategy does not, however, consider whether there is a need to run the Freedom Project in other languages to better engage victims whose first language is not English.

78. A very low number of children are privately fostered, with only three cases currently known to the local authority. When identified, private fostering arrangements are appropriately assessed and authorised. Plans work towards achieving better permanence options for privately fostered children, although these are not always achieved in a timely manner.

79. An advocacy service is available to children receiving services who are not looked after by the local authority. This is not effectively promoted to children by social workers and managers, and take up of the service is very low.

80. Appropriate attention is paid to diversity, with good and thoughtful use of interpreters when required. The workforce is also diverse, and that supports the authority in providing a good understanding of the different cultures present in Leicester City when assessing and planning for children.

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

Summary

The outcomes for children looked after are not yet good as a minority of children, when they are managed in the CIN teams, are experiencing drift and delay in the early stages of being looked after. Once transferred to the Looked After Child (LAC) service, outcomes for the large majority of children looked after improve because of better quality management oversight, continuity of social worker and timely social work visits.

The vast majority of children looked after live within 20 miles of their home, and a large majority are placed with foster carers or kinship carers. They are suitably matched with carers who are meeting their needs. Placement stability is improving.

The use of the Public Law Outline is improving and the average timescale for the conclusion of care proceedings has improved overall. The quality of court work is not yet consistently good.

Care planning is not informed by up-to-date holistic assessments, and permanence planning does not always start early enough. Care plans and personal education plans are not routinely acting as a vehicle for improving the experience and progress of children looked after. The Independent Reviewing Officers demonstrate effective challenge in improving practice but there is insufficient capacity within the service to address all aspects of quality in care planning.

There is good pastoral support in schools for children looked after but not enough is being done to ensure that the attainment gap with their peers in Leicester City's secondary schools is narrowed.

Though initial health assessments are not timely, children looked after are accessing good quality therapeutic support and a wide range of recreational activities, which improves their emotional and physical wellbeing.

Timeliness in effecting adoption plans is good. Children are matched and placed quickly and are supported well in their adoptive families.

The local authority is in contact with the vast majority of care leavers, and almost all care leavers spoken to say that they feel safe and well supported. Pathway and transition planning for looked after young people and care leavers post-16 is not yet consistently good. Too many care leavers are not in education, employment or training and lack an understanding of their health histories. Care leavers with complex needs are well supported through the Big Lottery funded Y-POD.

81. There has been a year-on-year steady increase in the number of children and young people looked after in Leicester City. At the time of the inspection, there were 542 children and young people looked after, compared with 533 at 31 March 2014 and 519 at 31 March 2013. Inspectors did not see any children or young people entering care who should not have done so. Decisions that children should become looked after are made at an appropriate senior level. However, inspectors did see a small number of children whose needs would have been better met by action being taken at an earlier stage to safeguard their welfare.

82. When children are made the subject of a permanence plan or a full care order they transfer to the LAC and 16+ service, which provides a service to 78% of children looked after. Workforce stability and improved management oversight in this part of children's services have contributed to improved outcomes for a large majority of children looked after.

83. The Public Law Outline (PLO) is not consistently used well by the CIN service to ensure that timely changes are made for children. At the time of the inspection, 54 children were subject to pre-proceedings and 64 children subject to care proceedings. Inspectors saw evidence of Legal Planning Meetings and Family Group Meetings being used effectively to suitably engage parents, resulting in some parents making the required changes. However, in other cases agreed actions within pre-proceedings work, such as initiating Legal Planning Meetings, had not been progressed in a sufficiently timely way.

84. When legal action is necessary, the timeliness of court proceedings overall is improving, having reduced from an average of 55 weeks in 2012–13 to 37 weeks in 2013–14. However, the second quarter data for 2014–15 show an increase, with the reported average duration of 34 weeks compared to 32 weeks in the first quarter of the year. This is above both the national and Leicestershire, Leicester City and Rutland (LLR) average of 30 weeks and does not meet the national requirement of 26 weeks. There is insufficient engagement by senior managers with the Courts and Cafcass to develop a joint understanding of the reasons for delay and to implement strategies to improve performance.

85. The multi-agency Children Looked After Resources Panel (LARP) provides an effective oversight of those children entering care, designing packages of support for reunification or continued looked after arrangements. Where possible, decisions are made in a planned way for children to return home to the care of their parents, supported by reunification plans, which are mostly robust and comprehensive.

86. When returning home from care, some children are benefiting from good multi-agency support under a child in need plan which helps their parents to maintain and build on progress. Whilst episodes of repeated accommodation are low (six children in the six months preceding this inspection), inspectors saw evidence of reunification plans not being consistently implemented by social workers, with insufficient independent scrutiny of arrangements immediately prior to, or immediately after, children returning home following a period of voluntary accommodation. Stronger management oversight is required to ensure that plans have been properly implemented and arrangements for the subsequent care of children by their parents appropriately assessed.

87. The experiences and progress of children subject to a court order returned home under Placement with Parents regulations are regularly monitored to ensure that the placement continues to meet the child's needs and that they do not remain subject to statutory orders unnecessarily. At the time of the inspection, 16 of the 18 children subject to such arrangements who are living at home have a plan for revocation of the care order, and five of these are subject to legal planning to commence the court process.

88. Social workers see the vast majority of children and young people alone. However, visits to their placement are not consistently conducted within statutory timescales. Management oversight of the extent of non-compliance is hampered by poor performance information. The impact of frequent changes in social workers, particularly within the Children in Need service, means that social workers do not always know children well, and children are denied the opportunity to develop trusting relationships with social workers at an early stage in their looked after experience. Children spoken to expressed their dislike of frequent changes in social worker. Once children have a plan for permanence, they are transferred to the Children Looked After service, where the majority benefit from more stable and meaningful relationships with social workers, many of whom are experienced and tenacious in advocating strongly on their behalf and ensuring that their rights and entitlements are safeguarded.

89. At the time of the inspection, 187 children were open to the Youth Offending Service, of whom 21 (11.2%) were looked after. Of these, five (23.8%) young people have re-offended, all of whom are placed in custody. Whilst on remand, care planning in respect of this vulnerable group of young people is mostly effective and includes active consideration of potential risk posed by others whilst they are in a secure establishment.

90. There is active consideration of potential risks associated with missing from care episodes and child sexual exploitation, although when this issue is identified, not all risk assessments are undertaken in a timely manner. At the time of the inspection, 29 young people looked after were assessed to be at risk of, or to have experienced, child sexual exploitation. In Quarter 3 of 2014–15, there were 81 missing from care episodes involving 32 children. The management of risk through multi-agency protection conferences and core groups is robust in the vast majority of cases, and children and young people who are reported as missing or absent from their placement are proactively looked for and their situations regularly monitored.

91. Timescales for the completion of initial health assessments for children looked after are poor, with only 11% conducted within 28 days during April to November 2014. This means that individual health needs may not be identified and responded to in a timely manner. Actions to remedy this, such as the introduction of a new secure email notification system, are very recent and yet to demonstrate an impact. Health partners acknowledge this issue and there are plans to increase capacity within their services to improve performance.

92. The vast majority of looked after children's health reviews, dental checks and immunisations are timely. Support for children and young people's mental health is provided by a specialist team within the Child and Adolescent Mental Health service (CAMHS) up to the age of 18 years. The Child and Family Support Service also provides a range of therapeutic interventions to children looked after, such as those relating to attachment, bereavement and loss, sexualised behaviour and post-abuse. Inspectors saw evidence of the positive impact of work undertaken by this team in improving young people's understanding of their life histories and family background and strengthening their self-esteem and confidence. The local authority does not, however, use tools such as the Strengths and Difficulties Questionnaire (SDQ) to help build a better understanding of the individual and collective emotional health and well-being of children looked after to inform care and service planning.

93. Most children looked after enter school from low starting points and, for those looked after for an average of two years or more, the rate of progress at the end of Key Stage 2 and Key Stage 4 is rarely better than the national average for similar groups. Performance in the GCSE examinations at 5A*-C in all subjects improves from year to year, but standards in the proportion gaining five or more GCSE grades A*-C including English and mathematics are well below that which is expected nationally and that of their peers locally. The rate of progress is not yet rapid enough to close the attainment gap, and the better progress being made at Key Stage 2 for some children is not sustained throughout Key Stages 3 and 4.

94. For some children, pupil premium funding is used imaginatively to support their education. The Virtual School provides strong pastoral support, for example, using music as a therapy to engage children looked after in their learning. However, the impact of the pupil premium is not consistently evaluated in personal education plans. The quality of personal education plans (PEPs) is too variable; though 50% of the PEPs seen by inspectors were good, 50% were of poor quality. In those of poor quality, targets are not consistently SMART and too often fail to address adequately what has to be done to improve performance. Better quality PEPs were evident when the social worker, school and Virtual School were fully engaged in their development and review.

95. Since 2012, attendance is much improved. It is currently 95%, which is better than the national average for all schools. 'Welfare Call' is used very well to liaise with schools on a daily basis and provide alerts. Effective pastoral support in schools, mentoring and additional funding from the Virtual School contribute to reducing fixed-term exclusions, but the authority has yet to reach their 10% target for fixed-term exclusions. In the last three years, only one looked after child has been permanently excluded. Currently, 15 children looked after are in alternative and complementary provision. Of these, two thirds are involved in full-time education and/or a combination with work-based learning linked to their assessed needs. The local authority is in the process of identifying suitable managed moves for the five remaining young people in Key Stage 3 who are not currently in receipt of full-time education.

96. The Virtual Head Teacher knows the children looked after well and ensures that the majority attend good or better schools. The Virtual School does not currently, have sufficient overview of the education progress of looked after young people in further education. A review of the structure of the Virtual School is underway, as the local authority recognises the need to develop a more effective and rigorous approach to challenging schools about the performance of children looked after, to accelerate a narrowing of the attainment gap.

97. Access to a range of social, educational and recreational opportunities is a consistent strength in Leicester City. Leisure passes, sporting activities, dancing and singing lessons and involvement in theatrical groups are positive examples of how social workers, residential staff and foster carers actively promote leisure as part of looked after children's care arrangements, and this contributes well to improving their physical and emotional health and well-being.

98. Care plans are not consistently good. Many are not updated on a regular basis and plans are not routinely informed by an updated assessment to reflect the child's changing needs and/or circumstances. A small minority of plans seen by inspectors were not sufficiently SMART, and in a minority of cases did not clearly outline the rationale for the specific permanence plan and how this was to be achieved.

99. Experienced Independent Reviewing Officers (IROs) review care plans regularly, and the vast majority of reviews (96%) are timely and involve key people in the child's life. There is evidence of challenge by IROs where plans are not sufficiently clear or where there is poor practice, and this leads to improved outcomes for some children. The IRO service, however, lacks sufficient capacity to fully address all aspects of quality assurance. The impact of changes of social workers and periods of children not having an allocated social worker means that IROs are too often engaged in discussions with social workers and team managers about 'getting the basics right', as one IRO put it. A small number of cases sampled by inspectors were referred to the local authority to ensure that plans for children are progressed in a timely manner. For some children, the impact of poor care planning has led to delays in securing their physical, emotional and legal permanence.

100. The large majority of children and young people live within foster homes that meet their heritage, social and emotional needs, and with their brothers and sisters where possible. 'Together or apart' assessments are undertaken to consider the contact needs of brothers and sisters and whether it is in their best interests to be placed together. Contact between children looked after and their family and friends is promoted well. A local contact centre contributes to parenting assessments, which form part of care plans. Children spoken to and their parents talked positively about the bespoke contact arrangements that are arranged for them and are well supported by social workers and their carers, particularly where children are placed out of the city.

101. 268 children (47% of the looked after population) live outside Leicester City, although 73% of these children are living within the county of Leicestershire and 87% are placed within 20 miles of Leicester City. Arrangements for children living within independently provided care placements are satisfactory. Social workers ensure that these children and young people have access to local health and education services, and more specialist services when required. The commissioning arrangements to monitor the quality of these placements are robust.

102. Foster carers are promptly assessed through the two-stage process to ensure that they are able to meet the needs of children. Spot purchasing of placements is used effectively to ensure that children who require foster care have access to placements that meet their complex needs. Most assessments of foster carers' suitability to foster are of an acceptable standard and demonstrate how carers will meet children's needs. However, supervising social work visits are not always timely enough to ensure that any issues are picked up promptly. Most foster carer files meet fostering regulations in relation to required documentation and checks to ensure that children are safely cared for. Foster carers have delegated authority to ensure that they are able to make day-to-day decisions in relation to the children and young people they care for, which helps to support and encourage children's emotional and social development.

103. The local authority offers sufficient training opportunities to foster carers, including online training. A low proportion of carers (32%) have completed the Training and Support Development (TSD) standards, and this is a declining picture from 2012–13 and significantly lower than the England average. Leicester City has a high number of kinship foster carer households, none of which have completed the TSD. Foster carer reviews are not timely and the majority of reviews do not address the training needs of carers nor how these needs can be met, resulting in the local authority not being able to adequately evidence how foster carers are developed to meet the changing needs of children.

104. The majority of children and young people looked after live in stable placements, which meet their needs well. Local authority data indicate that the proportion of children experiencing three or more placement moves in the last 12 months has improved from 13.2% in 2012–13 to 10.8% in 2013–14, although there are indications that this will rise marginally by the end of 2014–15. Improving placement stability is one of the key aims of the Prevention, Care Planning and Sufficiency Project, which is enabling the authority to develop a better understanding of the profile and needs of its looked after population. This is being used to inform future commissioning.

105. The local authority is making increasing use of special guardianship orders (SGOs) to secure children and young people's future, although the number overall remains comparatively low. In 2014, 27 children were made subject to an SGO compared to 19 children in 2013, the vast majority in respect of children living with 'connected persons'. In all cases seen by inspectors, decisions were appropriate and the support provided to carers was good, but in one of these cases an SGO could have been considered at an earlier stage for the child. The number of SGOs made to foster carers is low.

106. Preparation and matching for permanency, including adoption, is mostly good. Children's wishes and feelings are evident within assessments, case recording and plans, although not consistently strong in all cases. Case records and chronologies are not routinely up to date and the outcomes of children looked after reviews are not accessible on the system in a timely manner. Effective management oversight is inhibited by the use of different systems for recording information within the Looked After Children service. This means that the child's journey can be difficult to follow and information does not provide an up-to-date and accurate picture of the child's circumstances.

107. Children looked after have access to advocacy, provided by the Children's Rights Service, but take-up is relatively low; the limited capacity of the service means that it is operated on an 'opt-in' basis. Children's voices are represented through a well-established Children in Care Council, which works closely with the Corporate Parenting Forum to champion the rights and experiences of Leicester City children looked after and young people. A Children Looked After and Care Leavers Pledge is reviewed annually, and used in a thematic way to scrutinise services and identify areas for improvement, such as introducing work experience and apprenticeship opportunities for older looked after young people and care leavers, and improving contact between children and their social workers through the development of a mobile phone 'app'.

108. Good use of kinship carers enables children who become looked after to remain within their community or with family and friends with whom they have an established relationship and often share a common heritage. Social work practice is sensitive to children's cultural and religious needs, and there are examples of good practice supported by the work of the Heritage Panel.

The graded judgment for adoption performance is that it is good

109. There is a dedicated adoption team staffed by a stable and experienced workforce, with a good level of management oversight and a knowledgeable team manager who tracks and monitors performance. This helps to ensure that adoption processes are timely and of good quality.

110. Young children who are identified for permanence through adoption are matched and placed quickly with their adoptive families. The local authority performance against the Department of Education (DfE) adoption scorecard shows a positive picture in relation to both statistical neighbours and the national average. The average time from a child entering care to moving in with their adoptive family is 513 days, and the time between Placement Orders being made and the local authority deciding on an adoptive family match is 96 days. This latter figure is less than half that of neighbouring authorities and shows exceptional performance on matching children to their adoptive family. Children whose plan is for adoption do not wait longer than the national average for adoptive families from the time they enter care, and are placed quickly with their new families when matched.

111. Performance on the DfE adoption scorecard demonstrates that the Local Authority are performing well and showing an increasing trajectory of children being placed for adoption. In March 2014, there were 40 children with a Placement Order waiting for adoption. At the time of inspection, ten children had been identified as having a prospective match, with plans for presenting the match to panel imminent, and eight children were waiting for adoption. The local authority has achieved a significant reduction in the number of children waiting for adoption, successfully placing 22 children for adoption in the last 12 months, almost half being placed along with their brothers and sisters. This is a marked increase from the previous year (30 children) and is above both statistical neighbours and the England average.

112. Very few children experience a change of plan where adoption is the preferred permanence choice (four in the last 12 months), and where plans do change, these are informed by the assessed needs of the child. This demonstrates that where adoption is the permanence plan for a child, this is achieved for the large majority of children.

113. The local authority performance on placing older children, over the age of five years, in adoptive families is half that of statistical neighbours at 3%. In cases seen by inspectors, the authority has not given full consideration to adoption in permanence planning for a small minority of children early enough. Therefore, not all children have experienced sufficient opportunity to be placed in adoptive families. However, inspectors did see evidence of proactive family finding for children over the age of five, which resulted in some children being placed with adoptive families, including children who have additional needs, multiple complex heritage needs and those who need to live with their brothers and sisters.

114. The DfE adoption scorecard shows that recruitment of adopters has shown a slight decrease from 2013 from 34 adopters approved in 2012-2013 to 30 in 2013-2014. This is lower than statistical neighbours. Most adopters are assessed in a timely manner and the two-stage assessment process has been fully implemented in Leicester; 38% of adopters are approved within 3-6 months of application compared with the English average of 24%.Where there are delays in prospective adopters' assessment, these are not affecting children being matched with adoptive families. Adopters report that preparation training is of good quality and challenging, and they appreciate the involvement of birth families' experiences. The large majority of Prospective Adopter Reports (PAR's) are of a high quality, with evidence of good analysis and evaluation to ensure adopters' suitability to meet children's needs.

115. Consideration is given to brothers and sisters remaining together within an adoptive family where this meets the assessed needs of the children. Good quality 'Together or apart' assessments inform permanence plans and family finding; some children have remained with their brothers and sisters through the tenacity of the family finding efforts.

116. Fostering to adoption is in the very early stages of use, with some children who could have avoided a placement move not benefiting from this approach. The local authority policy and procedure is in draft form only, with a plan to review this prior to finalising. Adopters are asked as part of the assessment process whether they wish to be considered for Fostering to Adoption placements but the number of currently approved foster to adopt carers is low, reducing the pool of possible placement options for very young babies.

117. Evidence is clear of widening the net to find adoptive families for children in a timely manner when the local authority does not have in-house adopters. This is done through prompt referrals to the National Adoption Register, media promotion, and Adoption Activity days. This has resulted in some children living in adoptive families with their brothers and sisters, and most children from Black and minority ethnic groups are positively matched to meet all, or most, of their heritage needs. Disabled children and children whose developmental outcomes are uncertain have also been placed as a result of proactive family finding activities.

118. The local authority adoption panel is independently chaired with an experienced and knowledgeable chair, and the panel is appropriately diverse. Regular training and appraisal of the panel chair and panel members are undertaken to develop knowledge in relation to current issues. The panel offers a high level of challenge and probing to social workers and adopters to ensure the quality of reports and suitability of adopters. The Agency Decision Maker provides effective scrutiny to matching reports to endorse decisions to match children with their adoptive family. The process is clear and effective to ensure that children are appropriately placed with suitable families.

119. In a small number of cases seen by inspectors, Child Permanency Records (CPR'S) that are completed by the child's social worker are not of sufficient quality to give a full picture of the child's needs. Some CPR's do not give a clear enough rationale as to why adoption is the appropriate permanence option for the child. The quality assurance provided by the Adoption Panel is, however, robust and this ensures that children are appropriately matched with adopters. The local authority is aware of the variable quality of CPR's and has planned mandatory training for social workers to improve this area of practice.

120. Post-adoption support is a significant strength within the service and is provided by the Child and Family Support team (CFST). Pathways to support are clear and families are aware of the service and what can be provided. Adoption support has been provided to 23 children, young people and their families on a one-to-one basis over the last 10 months, and therapeutic oversight offered for a child placed for adoption out of county. Post-adoption support plans and reviews of intervention are child-centred, evaluative and analytical. The service offers timely intervention through one-to-one support based on evidenced therapeutic models such as theraplay. It has utilised its participation in the Adoption Support Fund National Pilot to offer more intensive services to children and their families where this is needed.

121. There have been no adoption disruptions in the last two years and the quality of the post-adoption service shows a clear contribution to this positive picture. It also provides an advisory role to schools, which includes how best to focus the use of the adoption pupil premium. The service is able to demonstrate positive progress for children, and some adopters spoken to by inspectors state that the service and intervention had enabled them to continue to care for their child where the family were approaching breakdown. One adopter said 'I don't think we could have done it without their support.'

122. The CFST offer support services to birth parents through independent birth parent counselling and, for adopted adults, birth records counselling is available, with the service supporting 70 adults since March 2014. Over 450 cases are supported through the post-box contact service and 10 adopted children are supported with ongoing direct contact with their birth families.

123. In cases seen by inspectors, the majority of children are being effectively prepared for permanence. However, in a minority of cases life story work is not carried out early enough with children to enable them to make sense of their place in the world. The majority of life story books seen are of good quality, but a minority lack the depth provided in the good examples seen by inspectors.

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

124. Performance management in the service is not well developed with reliable key performance indicators only very recently in place. This inhibits managers' understanding of the effectiveness and delivery of the service.

125. Caseloads in the 16 Plus service are high and personal advisors do not always have sufficient time to spend with care leavers. This has led to the service prioritising its intervention with young people aged 18 and over, for whom they hold sole case responsibility. The impact of this was seen during the inspection in respect of 16- and 17-year-old looked after young people, who had not met their personal advisor until many months after allocation. This impairs the timeliness and quality of transition planning.

126. The local authority is in touch with almost all of its care leavers and personal advisors are, in the main, tenacious in trying to maintain contact with young people. In a number of cases seen by inspectors there was too much emphasis placed on young people attending the office for contact rather than being visited in their accommodation, and this limits the effective monitoring of their welfare.

127. The vast majority of care leavers (96%) are living in suitable accommodation. Those young people identified as not living in suitable accommodation are predominantly not engaging or had experienced a number of placement breakdowns, despite receiving appropriate support from the service. There is one young person living in bed and breakfast accommodation who was about to move into independent living. Though well supported, a formal risk assessment had not been undertaken in respect of the accommodation, so the local authority could not be assured that this was a safe option.

128. Care leavers are prioritised for social housing and can access a range of accommodation options, including those supplied by the local authority, private rentals and those commissioned by the authority's placement scheme (including bespoke support packages). The range of accommodation has been extended in response to a consultation with young people through the Children in Care Council.

129. At the time of the inspection, the local authority could not evidence through their data collection process that they are accurately collecting data about which young people are living in a house of multiple occupancy, though inspectors identified none as living in accommodation that was of concern. Where the authority uses accommodation with less structured support, this is commissioned through the placements team and is subject to quality assurance and annual review to ensure suitability. These placements are normally only used where they are appropriate to a young person's individual needs and are not considered as a permanent housing solution.

130. Young people looked after are encouraged to remain in their fostering placements after they reach their 18th birthday through the local authority's Staying Put scheme. There are currently ten young people in such placements as the scheme is only in the early stages of its development.

131. Practice in respect of pathway planning is variable, and some pathway plans contain insufficient detail about actions, timescales and contingencies. The local authority has introduced a new pathway plan format developed in consultation with care leavers. Those seen during the inspection better reflected the views of care leavers, as well as giving improved attention to independent living skills, education, training and employment.

132. Personal assistants together with the young person complete most reviews, rather than at a formal multi-agency meeting, and in some cases, reviews had not taken place at all after young people had moved to unregulated settings. This approach is not consistent with the local authority's own policy and means that it is not able to assure itself of the appropriateness of young people's plans.

133. The proportion of care leavers in education, training or employment (EET) has risen from 41% in 2013–14 to 49% at the time of the inspection. Although this is a slightly improving picture, it is still not at a level the local authority would aspire to for its care leavers. The authority is trying to address this through a range of approaches, including closer partnership working with Connexions, the Virtual School, local colleges and universities. Higher Education experience days are promoted, and work placements are provided through the Leicestershire Cares Flying Fish project. Care leavers have priority access to the 16-19 bursary paid to young people in education or training. Currently 15 care leavers are attending university.

134. The local authority has its own pre-apprenticeship scheme for care leavers, in addition to the wider apprenticeships available, with 25 pre-apprenticeship and six apprenticeship places per year, ring-fenced for the care leaver group. Out of the six care leavers who undertook the apprenticeship scheme in 2014, three have secured permanent employment in the authority.

135. Care leavers access appropriate support for their health and well-being through a range of universal services. Care leavers with more complex needs are supported by a wraparound service via the Big Lottery funded Y-POD, and care leavers spoken to are positive about the support this had afforded them. Work is underway to further develop this approach through the transfer of the Care Leavers service to a new site in April 2015, which will offer a range of services to all care leavers through a multi-agency hub.

136. Care leavers are not routinely provided with information about their health histories, which means that they may not be aware of this important information. Out of a group of six care leavers spoken to, only one had an understanding of their health history. The local authority has not yet introduced a system for health passports, but reports that it has an action plan in place to develop this through the Care Leavers Strategic Board.

137. Currently there are 16 (8.65%) care leavers in custody, seven of whom are on remand. The 16 Plus service works collaboratively with the Youth Offending Service (YOS) to provide these young people with an appropriate level of support which includes joint visits. YOS workers attend key meetings to ensure a joined up approach to the needs of young people in custody.

138. The Disabled Children's Service provides sufficiently early notification to the Adults Social Care Transitions team for disabled young people to progress their transition to adult services. Feedback from young people and their carers identifies that while appropriate services and support are provided, current arrangements do not always meet the holistic needs of young people. The local authority has appropriate plans to improve transition services through the development of a more comprehensive 0-25 service. For example, two full-time health transitions coordinators are co-located in the Disabled Children's Service to coordinate the transition of young people's complex health plans. Parents spoken to said they value this additional support.

139. Almost all care leavers who were spoken to by inspectors reported that they felt safe. They were positive about the support they receive from their personal advisors in helping them to move towards independence or to live independently. The majority had some understanding about the entitlements they should receive from the local authority, such as access to financial support, including the leaving care grant, which the authority has set at the nationally recommended level of £2,000. The majority of this group were in possession of national insurance numbers and birth certificates. Although some information is available to care leavers regarding their entitlements, the local authority recognises that more work is required to strengthen care leavers' understanding about the support and entitlements available to them, and is currently in the process of developing an App to increase access to information.

140. The local authority has a pledge which sets out its commitment to provide support and entitlements to care leavers, and which young people have been involved in reviewing. Care leavers' achievements are celebrated through individual letters of commendation and annual celebration events, which care leavers are positive about.

Key judgement	Judgement grade
Leadership, management and governance	Inadequate

Summary

There has been a corporate failure of leadership and accountability for children's services in the local authority, with the leadership team and elected members failing to ensure that they have a robust understanding of the local authority's performance. The quality and accuracy of performance management information they receive, though improving, continues to be insufficient. Some of the recommendations from the last inspection in November 2011 are still areas of weakness today. Some of the strengths that inspection identified have deteriorated significantly.

A major restructure of children's services in May 2014 was poorly managed, culminating in a significant shortfall of social work and managerial staff in some parts of the service that has had a major adverse impact upon service delivery. The new Director of Children's Services (DCS) and Interim Assistant Director (AD) began addressing this with appropriate urgency when they came into post into October 2014; the workforce has now begun to stabilise, albeit through the services of a number of agency workers.

The DCS and AD swiftly established improvement plans and an Improvement Board to monitor their implementation. However, the poor quality performance information does not provide the plans with a secure foundation, and the DCS and AD acknowledged during the inspection that this deficit has impaired their ability to fully and accurately assess the service's strengths and weaknesses.

There is a collective commitment to improving services for vulnerable children that is reflected in the local authority's strategic planning and priorities, as demonstrated by the authority's current contribution to the multi-agency child sexual exploitation strategic activity. The DCS and AD have made significant progress with the most pressing issues, in a relatively short space of time. There is strong political support to deliver improvement and a commitment to provide the additional resources needed.

Although there are some strong partnership arrangements and some innovative plans to improve joint delivery of services, significant challenges remain. For example, engagement of partners in the delivery of early help is weak and there is currently no protocol between housing and social care to ensure that homeless young people age 16 and 17 years old are appropriately assessed.

The local authority has robust arrangements for learning from young people's experiences, and young people's participation is strong.

141. Services for children looked after and care leavers are not yet good and services for children who need help and protection are inadequate.

142. Some of the areas for improvement identified in the last inspection in November 2011 remain. This includes ensuring that the management oversight of cases is clearly recorded on children's records, with the reasons for the decisions taken, and ensuring that all plans clearly outline required outcomes, responsibilities and timescales. The quality of performance information and tracking mechanisms to enable regular monitoring of progress, which were identified as strengths at that inspection, have significantly deteriorated.

143. Key strategic decisions designed to make services more efficient and cost effective have had unintended negative consequences. A decision to move responsibility for performance management data to the corporate centre has over time contributed to inaccurate and insufficient reporting. This is compounded by poor systems for collection of data within the local authority's electronic recording system and inconsistent management oversight. As a result, managers, senior leaders and elected members do not have a detailed enough knowledge of what is happening at the front-line to discharge their individual and collective responsibilities effectively. The Performance Team moved back into Children's Services in mid-2014 and additional resources have been secured. The quality and accuracy of performance management information, is improving but remains insufficient to provide the level of accuracy, detail and analysis needed to support external scrutiny or robust quality assurance by managers.

144. The reorganisation of children's services that took place in May 2014, although based on sound principles, was poorly managed. The negative impact it has had on the quality, consistency and timeliness of services continues to be experienced to varying degrees by many children. This poor management of change resulted in low staff morale, lack of understanding of, and compliance with, newly introduced electronic systems, and organisational instability. This culminated in an increasing backlog of work in Child in Need teams due to staff turnover, which peaked in December 2014. On identifying the issue, the current DCS took action to ensure that cases were allocated. Following intensive recruitment of interim and agency staff, the backlog of unallocated work had largely been cleared at the point the inspection started.

145. Lack of good quality management information means that senior managers did not always know the extent of the issues identified through this inspection, such as the number of cases reallocated where children had not been seen and assessed. They also believed improvements were more advanced than was the reality, and were unaware that managers were not regularly reviewing the progress of single assessments to ensure timeliness and appropriate depth.

146. The local authority's evaluation of the quality of practice was over optimistic in nearly half of the 20 cases it audited for the purpose of this inspection. This included four cases that the local authority auditor had not recognised were inadequate until inspectors evaluated these. Auditors did not always recognise the impact of delay and drift on children, or note the impact of frequent changes in social worker and infrequent supervision on the quality of assessment and the delivery of plans in the child's timescale. Previous local authority audit activity found many of the same practice issues as seen during this inspection, but it has not been effective in improving practice. Further work needs to be undertaken with managers at every level to ensure that there is a shared understanding of good practice, that auditing practices are consistently robust and that learning from audits results in improved outcomes for children.

147. Though the Chief Operating Officer has regular meetings with the Director of Children's Services and with the Chair of the Local Safeguarding Board, his understanding of the quality and effectiveness of services and Board activity is affected by the lack of accurate performance information. Performance management is too reliant upon verbal reporting with insufficient scrutiny of data, agendas, minutes or attendance at meetings. Challenge to date has been insufficiently robust.

148. The Lead Member and Chief Operating Officer express confidence in the new Director of Children's Services and Interim Assistant Director and their ability to deliver the required improvements swiftly. There is political support for change and improvement and a commitment to providing the additional resources needed.

149. The recently established Improvement Board, comprised of senior managers, meets regularly. Its self-assessment, which was refreshed in December 2014, identifies many of the deficits seen in this inspection. They are included as part of the Improvement Board priorities and worked on as part of its action plan. However, the current improvement plans are too wide ranging, which means there is insufficient focus on getting the basics right first. Nor do they have clear enough outcome measures. Due to poor performance data and insufficiently robust managerial oversight, the Board does not have a detailed enough understanding of whether it is focusing on the right things, nor of the impact that improvement work is having on social work practice and outcomes for children.

150. The current DCS and Interim AD have made significant progress with the most pressing issue of stabilising and increasing capacity in the workforce in a relatively short space of time. A short-term workforce development plan has been successful in filling the majority of social work vacancies that resulted from the restructuring and associated changes. This has appropriately focused on recruiting permanent and interim staff of good quality. Interim staff are employed on longer-term contracts and are offered the same working conditions and training opportunities as the permanent workforce. Although this has resulted in immediate benefits, such as reducing staff caseloads to manageable levels and ensuring that almost all children have an allocated social worker, it is too early to tell if this strategy will succeed. In Children in Need teams, interim managers who have been employed by the local authority for less than six months fill the majority of team managers' posts. There remain significant challenges in ensuring consistency of managerial oversight based on a thorough knowledge of local policy and procedures due to the turnover of staff in this critical layer of management.

151. A longer-term workforce strategy is under development, and skills audits have been undertaken with early help and social care practitioners and frontline managers. This has informed a clear training and development programme which will help to establish baseline standards of practice across the children's workforce. Team managers are being offered training in leadership, supervision and managing performance. The progression of social workers is clearly linked to the Professional Capability Framework and the local authority funds post-qualifying opportunities for experienced staff. The authority has developed a policy that is ensuring that social workers have manageable caseloads.

152. Senior staff generally receive regular formal supervision that is appropriately aligned to organisational priorities, and to their professional development. A culture of robust supervision practice is being permeated down through the service by the senior leadership team, but is not yet embedded at all points in the system including, most crucially, at the front-line. The quality and frequency of formal supervision of social workers is far too variable, with frequent gaps and few examples of completed staff appraisals, making it difficult to evaluate workers' developmental needs and to support them. The templates used are inconsistent and do not follow the local authority guidance. Reflective supervision was not evident in supervision records.

153. Staff report improved visibility of senior managers, including the DCS and interim AD, and feel supported. Although almost all staff spoken to referred to the difficulties experienced since the service reorganised, the vast majority of them understood the local authority's vision for the future and wanted to be part of it.

154. There is a collective commitment to improving services for vulnerable children that is reflected in strategic planning and priorities. For example, there is strong strategic activity evident on tackling child sexual exploitation. The Children and Young People's Plan and City Mayor's delivery plan are closely aligned. The safeguarding of vulnerable children and the local authority's responsibility as a corporate parent are appropriately included as key priorities. They are not, however, included as priorities within the Health and Wellbeing Board's Strategic Plan. The local authority and partners recognise the alignment between the Board's priorities and other key strategic plans needs to be strengthened.

155. The current Joint Strategic Needs Assessment (JSNA) requires refreshing and this process has commenced. Prevalence information is insufficiently detailed to inform commissioning strategies or to project future need. The local authority estimate of prevalence of parental mental health issues is based on a research model, because this data is not collected, and so the estimate has no local factual basis to inform commissioning. There are ambitious plans to improve the effectiveness of joint commissioning arrangements through completion of a JSNA for children by autumn 2015, which will lead to a refresh of the Joint Health and Wellbeing Strategy in April 2016. It is expected that this will lead to more cost effective joint commissioning with a clear focus on improved outcomes, and result in greater alignment between the Health and Wellbeing Board's priorities and other strategic plans. However, this is at an early stage and the local authority recognises that it is not well placed to identify gaps in services, including in relation to children who live with parents who have multiple problems related to substance abuse, mental health, and domestic abuse.

156. The local authority sufficiency statements have identified gaps in its own placement resources to meet the needs of older children, those from minority ethnic groups and larger sibling groups. The authority spot purchases placements from independent fostering agencies and independent children's homes when unable to match appropriate placements from its own resources. Arrangements for the monitoring and quality assurance of these placements are appropriately rigorous. Findings are reported to the Local Safeguarding Children's Board and Corporate Parenting Board, ensuring strategic oversight.

157. The Scrutiny Commission is properly constituted and is well attended. Two young people attend regularly and are active members. It is tenacious in endeavouring to fulfil its function effectively, despite the lack of performance information to support its functions.

158. The Safeguarding Panel is constituted of elected members, and exercises a scrutiny role in respect of performance information relating to children's social care. Members of the Panel undertake Regulation 33 visits to Children's Homes, the outcomes of which are reported to the Panel. The Panel has ensured that all councillors receive regular safeguarding training and, through effective challenge, has helped to ensure the sufficiency of child sexual exploitation training for professionals working with children and young people.

159. The Lead Member chairs the Corporate Parenting Forum, which includes two young people from the Children in Care Council, and this is well established and suitably aspirational. It does not, however, have a sufficient understanding of the performance of local services and their impact on all outcomes for children looked after and care leavers. The lack of regular reporting of performance information and audit activity, including oversight from the Independent Reviewing Officer Service, means that challenge and priority setting is not linked strongly enough to what is happening to children and young people, the quality of services being provided to them and their outcomes. In the absence of good quality performance information, it does use other sources of intelligence, and its scrutiny of the quality of care leavers' accommodation led to visits by Forum members to provision. This resulted in the closure of an establishment found to be providing unsuitable accommodation and support.

160. Strategic partnership working with the Family Justice Board and Cafcass is weak due to the local authority's poor engagement in the Board and its Performance Sub-Group. The opportunities this group offers to develop more effective partnership working, and for the authority to influence improved joint performance with regard to the length of care proceedings and the quality of court reports, have not been prioritised.

161. The local authority aspires to be a learning organisation and has mechanisms in place for learning from themes arising from advocacy and complaints. Learning from the Local Government Association Peer Health and Wellbeing Challenge undertaken in February 2014 led to the lead member for children's services becoming a member of the Health and Wellbeing Board and other learning from this challenge has been incorporated into its improvement planning, as have best practice examples drawn from research. It undertakes its own research to inform best planning for individual children and future service configuration. The Prevention, Care Planning and Sufficiency project, for example, gives a detailed analysis of the last five years' data on the profile of children looked after. It outlines appropriate key aims, including improving provision of early help and help to children at the edge of care. The benefits of this activity are, however, constrained by the local authority's overall lack of knowledge and understanding about its own performance.

162. Young people's participation is strong. Young people sit on strategic panels, there is an active and enthusiastic Children in Care Council, and groups such as 'Big Mouth' and 'Little Mouth' provide an opportunity for disabled young people to make their voices heard.

163. The local authority responds well to children's diversity needs in relation to race, culture and sexuality; for example, through appropriate use of interpreters and referral to the Heritage Panel, which considers ways of improving practice and identifies gaps in services, and provides support and advice to practitioners to ensure that the heritage needs of children receiving services are met.

The Local Safeguarding Children Board (LSCB)

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

Summary of findings

The LSCB is inadequate because:

Scrutiny, awareness and challenge

- The Board's recent arrangements to monitor frontline local authority practice have been ineffective. As a result, it has not had sufficient awareness and understanding of the weaknesses in key child protection services such as those within children's social care. This lack of effective scrutiny has meant that it has not held agencies sufficiently to account to improve these services.
- The Board has not been receiving adequate performance management data of safeguarding activity from partners and it is therefore unable to hold agencies effectively to account.
- The Board has not provided robust challenge to the partners nor ensured effective co-ordination of all key services. The good engagement of board members has not resulted in meaningful impact upon front line practice.
- Engagement with young people in order to drive improvement to safeguarding practice and effectiveness is at an early stage, so its work is not yet directly informed by the views of young people.

Quality and evaluation

- The Board has not provided effective scrutiny to evaluate the impact of the early help offer. Partners are not clear about their early help responsibilities, and referral thresholds are not well understood.
- Although the Board has been aware of major changes that have taken place within the local authority in the past nine months, it has not foreseen or assessed the impact of these on the workforce and their practice.
- The Board's own understanding of the quality of practice is restricted by limited audit activity within the partnership.
- The development of a child sexual exploitation strategy is at a relatively early stage and it is too soon to evaluate impact. Training has not been sufficiently targeted to ensure that practitioners understand and act upon the indicators of child sexual exploitation.

What does the LSCB need to improve?

Priority and immediate action

164. Establish and implement a robust performance management framework and dataset that can enable the Board to exercise scrutiny of service effectiveness and outcomes for children. This should include reliable quantitative data, qualitative information, service user's views and experiences and practitioner's views.

165. Monitor the effectiveness of statutory services and practice provided to children in need of help and protection.

166. Establish a clear line of sight and reporting from front line practice to the Board so that concerns and challenges can be identified more promptly and accurately.

Areas for improvement

Scrutiny, awareness and challenge

167. Ensure that the information reported to the Board contains challenging analysis that enables members to identify the key priority areas for improvement and generate an effective Business Plan.

168. Increase the number frequency and range of multi-agency audits initiated by the Board.

169. Produce and implement a plan to engage with children and young people in order to hear and act upon their voice.

Quality and evaluation

170. Produce an Annual Report that is consistent with all the requirements of Working Together (March 2013).

171. Evaluate the current operation of the early help offer, including partners understanding and implementation of their early help responsibilities and the understanding and application of service thresholds.

172. Ensure that an evaluation of the impact of recent CSE initiatives relating to prevention, protection, prosecution and disruption is undertaken and that the right support is being made available to victims.

Inspection judgement about the LSCB

173. Leicester City LSCB is properly constituted and has appropriate representation from partner agencies. It has appropriate links and protocols with the Children's Trust and the Health and Wellbeing Board, although safeguarding children has not been a regular agenda item at the HWBB. The Chair meets regularly with the City Mayor, Lead Member and senior officers of the council and has a programme of formal meetings with Chief Executives of statutory partners and officers. Through these meetings, the Chair has raised a number of challenges including in key areas such as the need to improve performance monitoring and to listen to the voice of the child. However, at the time of the inspection the local authority had not made these improvements. There is an appropriate range of sub-groups, chaired for the most part at a suitable level, but which operate with different levels of effectiveness. The Safeguarding Effectiveness Group, in particular, is not driving improvement. The Board has joint working arrangements with the Boards in Leicestershire and Rutland. The LSCB Chair is also Chair of the Safeguarding Adults Board, and there is good engagement with agencies and services that focus on adults. The local Health Trusts are engaged and Leicestershire Police is a particularly vigorous partner.

174. The LSCB undertook a review of its own governance from September 2014, seeking to ensure that its constitution, membership and chairing of sub-groups were fit for purpose. The current business plan is mainly aspirational and is not supported by good quality management information. Similarly, the annual report is not supported by robust performance data and, although it does set out its priorities, including recognition of the weaknesses identified in this inspection, there is no cogent plan to deliver them. The revised governance arrangements were approved by the Board in December 2014 and have been implemented. The reforms include a new framework for the Business Plan, which sets out how priorities will be identified and delivered.

175. The Annual Report for 2013–14 does express the commitment to improve the quality and consistency of work with families, but does not set out a clear plan of how the Board will assist in doing this. It is not sufficiently challenging of partners and is not supported by performance information. There is little analysis and it does not clearly enough identify key areas of weakness or vulnerability which require improvement. The report does not therefore provide a rigorous assessment of the performance and effectiveness of local services.

176. The Board has received an Indicators Report in 2014, which is the beginning of a dataset that is appropriate for Board members to use as the basis for mutual challenge. However, the report is heavily reliant on local authority data, which is incomplete and not fully reliable. There are key and basic gaps in the data available to the Board. It does not receive data on the attendance of parents, young people or agencies at Child Protection Conferences, for example. The Demands Reports, which the Board receives as a measure of service pressures, are helpful but are not supported by performance information and are too discursive in nature. The local authority understands that the implementation of its client information system has been problematic, and accurate data collection and analysis are not yet completely reliable; this is hampering the Board in its efforts to identify and grasp key performance issues. The Safeguarding Effectiveness Group has expressed an intention to bring together multi-agency datasets in a Results Based Analysis model and 'overlay' these in order to produce a picture of partnership working, yet at present there is not an adequate dataset, nor analysis, which meets basic requirements.

177. Arrangements to monitor the effectiveness of multi-agency frontline practice are not well developed. The system of monthly Multi Agency Case File Audits (MACFAs), where practitioners come together with agency leads to discuss one case, does not give sufficient coverage of the range of vulnerable children. Only eight MACFAs were held during 2014. No thematic audits are undertaken. The experiences of young people are not yet being collected and used to inform service improvement. The Board is not fully sighted on frontline practice and cannot therefore hold agencies properly to account.

178. LSCB partners make appropriate contributions to the overall work of the Board, which is well resourced. All agency Section 11 audits have been signed off following a senior officers' challenge meeting attended by all statutory partners. The LSCB has identified the need for a more robust Section 11 process in August 2014 and this is now being implemented.

179. A Learning and Improvement Framework is in place, which sets out how the learning from review processes, audits, performance information and external scrutiny will be taken forward. However, there is evidence that at least two of these four arms are insufficiently developed. Serious Case Reviews have been effectively managed and published, and the learning captured and disseminated to staff at multi-agency events, although several social workers spoken to had not had the opportunity to attend the briefing sessions. Learning from serious case reviews, both local and national, also informs to LSCB training and audit programme. The Board receives the annual report of the Child Death Overview Panel, which is chaired by the Consultant in Public Health. The CDOP report for 2013–14 did contain some analysis of cases reviewed and made appropriate recommendations for health agencies.

180. Policies and procedures are in place; however, the impact of these has not been formally evaluated. Revised procedures were implemented in October 2013 and are compliant with the Working Together 2013 statutory guidance.

181. The Thresholds document, which sets out partner responsibility for working with families at various levels of complexity, was re-issued in early 2014. The current early help strategy has not had sufficient buy-in from partners, and some practitioners are continuing to refer inappropriately to social care and appear unaware of their responsibility to carry out an early help assessment. The number of early help assessments fell significantly (by 23.1 %) from quarter 1 to quarter 2 during 2014, and this downward trend was reported to the Board by the Safeguarding Effectiveness Group as a critical issue but this has not yet received an effective response.

182. Child sexual exploitation has been a local priority area for the Board for several years but the increased national focus has led to a Leicester, Leicestershire and Rutland (LLR) joint strategic approach, which is now driven by the LLR Child Sexual Exploitation, Missing and Trafficking sub group. This group is developing an understanding of prevalence across the three local authorities through an analysis of the data held by a range of agencies. An operational multi-agency Child Sexual Exploitation group has been established that also works across the three local authorities and this aims to establish a tri-borough multi-agency hub. In Leicester City, a range of awareness-raising materials has been produced and circulated and over 8000 young people have been engaged through the film 'Chelsea's Choice'. There is training and a toolkit available to elements of the private sector, such as taxi firms and hotels. A training programme is in place but more work needs to be done to ensure that this is effectively targeted and to ensure its impact is evaluated. Weekly multi-agency meetings share intelligence and plan disruption activity. The Board is at the beginning of an understanding of the issue of radicalisation and it is too early to demonstrate any impact of this work.

183. The LSCB has in the past been an influential participant in helping to monitor and shape services for children in Leicester. When the partnership became concerned at the high level of contacts and referrals from partners coming into Social Care, it commissioned an evaluation of the work at the 'front door' which was undertaken during 2013. This resulted in the creation of the Duty and Advice Service that was working well at the time of the inspection. However, the quality of the Board's scrutiny more recently has been insufficient. Multiple changes enacted during 2014 had powerful and unintended consequences. These changes included the closure of some area offices and a centralisation of staffing, the introduction of a new client information system and a new telephone system. The impact of this poorly managed change and lack of positive staff engagement led to a high level of staff turnover in children's social care and affected the quality of frontline practice in some teams. Information presented by partners to the Board on the impact of these changes was not sufficiently timely or robust and the Board was too slow in seeking this information or acting on the concerns it did have. As a result, the Board was ineffective in providing robust challenge and holding agencies to account. It was hampered in this by management changes and gaps in the business and professional support provided to the Board. The Board has recently begun to acknowledge and appreciate the severity of these problems.

184. Multi-agency training in child safeguarding is available to practitioners in Leicester and this and attendees report that it is of good quality; a project coordinator supports this. Evaluation of training impact on practice is beginning, and a voluntary sector organisation is commissioned to report on the impact of the learning and development offer. Attendance at training events is increasing and the number of no-shows is reducing.

What the inspection judgements mean

The Local Authority

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

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

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

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

The LSCB

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

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

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

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

Information about this inspection

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

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

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

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

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

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

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