# Lancashire

## 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 September 2015 – 8 October 2015**

**Report published: 27 November 2015**

| **Children's services in Lancashire are inadequate** | | |
|---|---|---|
| **1. Children who need help and protection** | | Inadequate |
| **2. Children looked after and achieving permanence** | | Requires improvement |
| | 2.1 Adoption performance | Requires improvement |
| | 2.2 Experiences and progress of care leavers | Inadequate |
| **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 Inspections Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

## Executive summary

There are serious failures in the services provided to children who need help and protection in Lancashire. Services for care leavers are also poor, with few receiving the level of support they need to enter adult life successfully. Services for looked after children and children in need of adoption are not yet good. All services have significantly deteriorated since the last inspection of children's services published in March 2012, when the local authority was found to be good overall with some outstanding features.

During the inspection, three children tragically died in unrelated incidents. Their families were open cases to children's social care and they were receiving services as children in need. Investigations of the children's circumstances are at an early stage and it is too soon to establish if their deaths could have been prevented. Inspectors looked at the social work records of these children with senior managers from the local authority, who agreed some of the practice was poor. Some of this poor practice was seen in a much larger number of cases where children had not been harmed.

Inspectors referred back five cases to the local authority where there were serious issues of concern and 11 cases where there were concerns that the service offer or risk assessment may not be appropriate for the child's needs. In 13 of the 16 cases, inspectors' concerns were substantiated. Although this is a small number of children relative to the population of Lancashire, elements of the poor practices in these cases were apparent in many others. These widespread concerns included a failure to involve key agencies in strategy discussions at all stages of child protection enquiries, resulting in inappropriate decisions in some cases; assessment of risk without reference to or knowledge of significant history; complex work allocated to practitioners with insufficient qualifications or experience; and a lack of effective management oversight, particularly of children in need work. In some cases there was an over-reliance on parents' compliance with written agreements to keep children safe. A small number of older young people at significant risk of harm were not recognised as meeting the threshold for a child protection conference.

Services were restructured in April 2015 in line with a corporate vision of providing lifelong services with as few transition points as possible. Arrangements for consideration of contact and referrals are efficient and effective. From this point onwards, generic locality teams cover a full range of services for children from those in need of help and protection to care leavers. Significant staff turnover, much of it due to internal promotion, has resulted in an inexperienced workforce covering a broad range of work requiring more detailed and specialist knowledge than it is often equipped to offer. This has led to a failure to comply with some statutory guidance, for example in relation to children who are privately fostered.

Following assessment by qualified social workers, much child in need work, including some complex cases, is held by family support workers. Inspectors found systemic weaknesses in management oversight of this work, with no checkpoints or protocols

for qualified workers to regularly review or update families' circumstances to ensure that risk continues to be managed at an appropriate level.

A combination of generic workloads and complex, often demanding, work means that children and young people whose needs are less immediate or obvious do not always receive sufficient priority. Care leavers are particularly poorly served. In too many cases they receive incomplete or conflicting information about their entitlements, a lack of effective support to engage or re-engage with education or employment and insufficient support with housing issues until they reach crisis point.

Services for looked after children require improvement, with many benefiting from stable and secure placements. The quality of practice, however, remains too variable. A recently renewed focus on promoting the educational attainment of looked after children has not yet resulted in enough looked after children having the most basic tools to support educational achievement, such as a personal education plan. Educational aspirations for them remain too low, particularly once they reach 16. Many looked after children still wait too long for permanence and do not receive timely help to understand their past experiences.

Adoption performance is improving and children receive good-quality support post-adoption. However, there is no centralised strategic oversight of the service, leading to delay for some children.

Attention paid to the identity and diversity needs of children in every part of the service is too often superficial or in some cases absent.

Performance management information is very poor and the local authority struggled to provide inspectors with basic accurate data such as the number of care leavers it was in touch with or the number of assessments it had completed. As a result, senior leaders and elected members cannot be confident that reported changes in performance are accurate. This reduces the effectiveness of their oversight of the quality of service that children receive. While senior leaders and elected members are appropriately ambitious to improve services in Lancashire, a general lack of target-setting and agreed benchmarks significantly reduces their ability to hold each other to account or to communicate clear expectations to staff. Poor-quality information is to an extent mitigated by extensive audit activity undertaken by the local authority and its partners. Audits had already identified many of the deficits seen in this inspection but had not resulted in development of effective action plans or led to improvement in performance.

The local authority has recently responded to these long-standing challenges by commissioning an external provider to review its current services with a view to improving outcomes and identifying efficiencies. This work has not yet started.

This executive summary should be read alongside the recommendations in the next section of this report. Each recommendation is clearly linked to the relevant paragraph(s) that set out the detailed findings of this inspection.

# Contents

# The local authority

## Information about this local authority area[2]

### Previous Ofsted inspections

- The local authority operates 10 children's homes and seven overnight breaks units for children and young people with special educational needs and learning difficulties and/or disabilities. Twelve of these were judged to be good or outstanding in their most recent Ofsted inspection.
- The previous inspection of Lancashire's safeguarding arrangements was in January 2012. The local authority was judged to be good.
- The previous inspection of the local authority's services for looked after children was in January 2012. The local authority was judged to be good.

### Local leadership

- The Director of Children's Services has been in post since April 2015.
- The Chair of the Local Safeguarding Children Board has been in post since March 2014.

### Children living in this area

- Approximately 244,755 children and young people under the age of 18 years live in Lancashire. This is 21% of the total population in the area.
- Approximately 18% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 14% (the national level is 16%)
  - in secondary schools is 12% (the national level is 14%).
- Children and young people from minority ethnic groups account for 13% 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 (10%) and Mixed (3%).
- The proportion of children and young people with English as an additional language:
  - in primary schools is 12% (the national level is 19%)
  - in secondary schools is 9% (the national level is 15%).

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

## Child protection in this area

- At 31 August 2015, 9,140 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 8,534 at 31 March 2015
- At 31 August 2015, 1,054 children and young people were the subject of a child protection plan. This is a increase from 936 at 31 March 2015.
- At 31 August 2015, 32 children lived in a privately arranged fostering placement. This is an increase from 28 at 31 March 2015.
- Since the last inspection, 24 serious incident notifications have been submitted to Ofsted and eight serious case reviews have been completed or were ongoing at the time of the inspection.

## Children looked after in this area

- At 31 August 2015, 1,577 children are being looked after by the local authority (a rate of 64.4 per 10,000 children). This is a decrease from 1,610 (a rate of 66.0 per 10,000 children) at 31 March 2015.
  - Of this number, 277 (or 17.6%) live outside the local authority area.
  - 119 live in residential children's homes, of whom 24.4% live out of the authority area.
  - Four live in residential special schools,[3] of whom 75.0% live out of the authority area.
  - 1,004 live with foster families, of whom 17.9% live out of the authority area.
  - 221 live with parents, of whom 9.0% live out of the authority area.
  - There is a very small number of unaccompanied asylum-seeking children.
- In the last 12 months (between 1 September 2014 and 31 August 2015):
  - there have been 112 adoptions
  - 136 children became subject of special guardianship orders
  - 441 children ceased to be looked after, of whom 18 (4%) subsequently returned to be looked after
  - 51 children and young people ceased to be looked after and moved on to independent living
  - three children and young people ceased to be looked after and are now living in houses of multiple occupation.

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

## Recommendations

1. Ensure robust performance information is available to support effective management scrutiny and challenge to poor performance at all levels of the organisation (paragraphs 21, 32, 43, 49, 52, 53, 110, 111, 115, 116, 122, 123, 124).

2. Review the way in which audit work is undertaken and evaluated to ensure it is used effectively to drive improvement in the quality of front-line social work practice (paragraphs 125, 126, 127, 136).

3. Ensure elected members have an accurate understanding of the quality of service provided to children to enable rigorous challenge to senior managers to make improvements (paragraphs 121, 123, 132, 133).

4. Develop and implement a strategy that addresses the specific needs of the current workforce including ensuring the required levels of support and supervision for newly qualified staff (paragraphs 37, 111, 135, 136, 137).

5. Ensure that all child protection investigations are conducted by suitably skilled, knowledgeable and experienced social workers (paragraph 28).

6. Ensure that strategy discussions are held when the threshold is reached, are clearly recorded, and that they always include the police and health professionals in planning and considering the outcome of child protection investigations (paragraph 27).

7. Ensure that assessments and plans are informed by historical information and diversity factors and that they focus on the experience of the child and accurately assess risk (paragraphs 23, 28, 29, 33, 54, 56).

8. Provide all children in need with sufficient oversight from qualified social workers and managers to ensure robust care planning and on-going effective analysis of risk (paragraphs 36, 37,121, 136).

9. Monitor and review the use of written agreements with parents to ensure they are not relied on to manage risk when a child in need plan, child protection plan or legal action is required instead. Ensure that managers' decisions recorded on cases files explain what evidence they have considered and on what basis their decision has been reached (paragraphs 35, 36, 135).

10. In cases with an additional focus, such as forced marriage or honour-based violence, ensure that social workers understand the importance of also initiating child protection procedures when the victim is a child (paragraph 51).

11. Ensure that children who are privately fostered and their carers are assessed and visited within required timescales (paragraph 52).

12. Ensure that the need for permanence for all looked after children is considered at an early stage and is regularly reviewed (paragraphs 57, 58).

13. Ensure that all looked after children have regularly updated personal education plans that are effective in supporting their educational progress and attainment throughout their childhood (paragraph 75).

14. Ensure that the independent reviewing service undertakes consistent regular oversight of practice and care planning in children's cases in line with the Care Planning Placement and Case Review Regulations 2010 (paragraphs 57, 60).

15. Ensure that managers of the service maintain a strategic overview of the experience of children from the point they enter care to adoption or permanency that is sufficiently rigorous to prevent drift and delay and assist with identifying and predicting future placement needs (paragraphs 58, 80, 94).

16. Ensure that all looked after children who need it receive timely life story work so they understand their history and what has happened in their lives (paragraph 105).

17. Ensure that care leavers receive the level of support and information they require to successfully make a transition to independence, including accurate information about their entitlements; effective support in engaging or re-engaging with education, employment or training; and that pathway plans effectively address the key needs of care leavers (paragraphs 84, 107, 111, 112, 115, 116).

## Summary for children and young people

- Children who need help and protection in Lancashire do not always get the right level of support to keep them safe. Social workers do not always understand important things that have happened to children in the past. Sometimes they do not talk to all the people who have important information to help them decide the best thing to do. In a few cases they do not act quickly enough to protect children.
- Staff work hard and try to give children a good service. Senior managers have not made sure that all staff have the training they need to do their job well and sometimes they expect them to do things they do not have the qualifications or experience to do.
- Senior managers, and people who run the council, want to do a good job but do not have enough accurate information about how services are doing to make sure they concentrate on improving the right things.
- Young people who are looked after do not get enough help with their education or job prospects, particularly after they reach 16. This can give young people the impression that the local authority does not care what happens to them once they leave school.
- Some care leavers do not always feel the local authority has been a good parent to them. They do not receive all the help or information they need to be successful in their adult lives.
- Looked after children generally live in placements with people who understand and meet their needs well.
- More children who need it have been adopted, although some still wait too long for a family. Adopted children and their families receive good support that helps them settle in well.
- The council is interested in what children have to say. They make sure they involve them in important decisions about how services are run.

| The experiences and progress of children who need help and protection | Inadequate |
|---|---|

**Summary**

Widespread failure to follow procedures and inconsistent practice across help and protection services leaves some children and young people at risk of harm. In a very small number of cases seen children suffered harm before the correct action was taken. A high proportion (50%) of social workers undertaking complex child protection work have less than two years' experience. The managerial oversight and support to workers who lack experience to practice safely is insufficient. Child protection strategy discussions are not always held when they should be. Many held do not have the correct minimum representation of agencies and some only involve social care.

Assessments do not consistently identify or consider all risks to children and young people. Few sufficiently consider the family's history, and some do not demonstrate a thorough understanding of the child's experience. Inspectors saw a small number of cases where poor assessments had led to children receiving services as children in need when risks were such that a child protection response was needed. Children who are victims of honour-based violence or forced marriage are supported by the police and social care, but in cases seen social workers and their managers did not always recognise they were also children in need of protection.

Children's plans are often not clear or outcome-focused and frequently contain no timescales. This makes measuring progress difficult. Family support workers manage cases of children in need, including even some complex cases where a level of risk is present. In some cases child protection plans end before professionals could be satisfied that the level of risk had reduced enough. They step down to child in need cases, leaving family support workers to oversee continuing reduction of risk. Child in need cases do not have sufficient managerial or qualified social worker oversight. Reviews in these cases do not benefit from the attendance of a qualified social work professional and are not always effective in challenging lack of progress. In a small number of cases seen, increasing or continuing risk to children was not recognised, leaving children at risk of harm. Written agreements with parents are relied upon inappropriately in some cases as the only means of managing risk to children.

Social workers receive regular supervision and value the support they receive from frontline managers. Management oversight is included on case files but frequently lacks a rationale for decisions made. This makes it difficult to establish if the manager considered all known key factors prior to making a decision. The electronic information system does not support good assessment or planning, or provide good quality management information to assist managers. Children who are privately fostered in Lancashire are not sufficiently monitored to ensure their safety and well-being.

## Inspection findings

18. In 2015, the local authority completed a major review of the early help offer across Lancashire, with the aim of improving efficiency and take-up of services. The first phase of the resultant service restructure has been implemented, but at the time of the inspection a significant number of the local authority funded posts in the early help team (around 40%) were not filled, which has slowed progress.

19. Since 2012, as the result of effective partnership working between the authority's staff and partner organisations, a high proportion of 'troubled families' (87% of 2,281) has been 'turned around' as of May 2015, with improvements in economic well-being and their children's life chances. The local authority does not have the means to measure the effectiveness of the help offered to these families over time and therefore does not know how many have sustained their improved well-being.

20. In 2014, the authority provided an extensive training programme on the common assessment framework (CAF), which a significant number of staff in its partner organisations completed. At least one member of staff in each organisation, including schools and health, has trained as a 'CAF champion', supporting others when completing a CAF. The training included helpful guidelines on applying thresholds. As a result, an increasing number of early help assessments and interventions are completed; for example, from September 2014 to August 2015, 5,048 assessments were initiated, of which education providers initiated 1,298 and children's centres 1,523.

21. Although numbers are increasing, the quality of CAFs is not good enough. Often they lack clear and detailed action plans and do not always include children's views. Basic details of children's identity needs, such as their ethnicity, are not always recorded. In recognition of this, managers have developed a quality improvement system, which includes feedback to individuals who initiate a CAF, but this is not yet implemented. The plan to introduce a web-based CAF that can be easily accessed by relevant professionals is at the early stages.

22. Schools have a strong focus on safeguarding children. Staff in schools have had good-quality training in the 'Prevent' agenda, and this has given them confidence to intervene to reduce the risk of radicalisation. They use CAF appropriately when there are emerging concerns that children could become at risk of child sexual exploitation or harm through domestic abuse. However, not all schools have a clear understanding of the agreed local thresholds for intervention and some CAFs result in children being referred to children's social care for a social work assessment when they do not need one. This can result in delays in intervention for some children.

23. Children's centres contribute well to early help provision in Lancashire. They know the population in their reach areas well, understanding the challenges

that the parents and their children face. They provide a good range of relevant services to parents of children in need, including alcohol and domestic violence awareness programmes. Staff in children's centres also offer parents advice and guidance about accessing education, training or employment, and when required, direct them to other services offered by partner organisations.

24. Lancashire has two separate routes for agencies to refer children and young people who have reached the threshold for social work intervention to the local authority. When the police identify that a child or young person may require additional support, cases are managed via Lancashire Multi-agency Safeguarding Hub (MASH). All other agencies contact Lancashire's Contact and Referral Team (CART), which is co-located with the MASH. Through the MASH, children and young people benefit from a multi-agency response from Monday to Friday. At weekends, the police alone deliver the MASH, operating from the same base as the local authority's out of hours team, which also manages urgent referrals that are normally processed by the CART. This system, though complex, is efficient. Information is shared effectively between daytime and out of hours services at a management level to ensure appropriate handover of cases. Decision-making by the CART and MASH is timely and cases are correctly passed to localities when a social work assessment is required. When this is not the case, referrers are appropriately redirected to other services or early help. The co-location of staff at the MASH supports multi-agency information-gathering and assessment. The authority plans to simplify current arrangements by expanding the MASH to cover all referrals.

25. Referrals, including those where children are potentially at risk of harm, are reviewed and allocated promptly to social workers on duty in locality teams for assessment. However, not all cases that meet the threshold requiring a child protection investigation are correctly identified. In a small number of cases seen by inspectors, children had suffered harm prior to the correct action being taken. Strategy discussions to plan and consider outcomes of child protection investigations are often poorly conducted and recorded. In many cases, social workers use information from the referral or gather it via phone calls to other agencies, then agree actions by phone with the police. In others, the discussion involved only the social worker and their practice manager. This is contrary to national guidance and fails to ensure that all key information is gathered and considered to minimise risk to children. In a small number of cases seen, failure to include key partners, such as health professionals, in decisions following the outcome of child protection enquiries led to conclusions that did not give sufficient weight to important information.

26. Approximately 50% of frontline social workers have less than two years experience and just under half of those have been qualified for less than one year. In some teams, these social workers have caseloads that the local authority recognises are too high. Inspectors saw social workers with limited experience undertaking child protection investigations. In one case, the

manager was intending to send a social worker with only six weeks post-qualification experience to undertake a child protection investigation. Senior managers within the local authority did not accept that this was an inappropriate allocation of work. In another set of cases, youth offending team social workers with no previous experience of the work were required to undertake assessments of children where the level of risk was unknown due to work pressures elsewhere in the system. In a number of cases seen, the social workers' ability to assess risk was limited. Key historical information and wider factors were not appropriately considered.

27. The local authority is not able to ensure that records are accurate and has difficulties in retrieving information from the electronic social care record. It has particular difficulty in ensuring that social workers maintain up-to-date chronologies other than in cases before the court. This means that social workers do not routinely consider history when completing assessments, which limits the value of the work and can mask patterns and long-term risk. Inspectors considered practice in over 60 cases with recent child protection concerns or investigations. In around a fifth of these, inspectors identified that either processes to safeguard children were not correctly followed or an inadequate identification of risk potentially left children at risk of harm.

28. Changes in the way locality teams operate mean all social workers now undertake the full range of social work from duty through to the conclusion of care proceedings, including planning for adoption and permanence. This means that even the most experienced social workers are taking on areas of work that are new to them. Given the range of expertise that is now required, there is not enough management oversight or support for less experienced staff to ensure they can safely manage the cases they are allocated.

29. In order to improve decision-making in relation to child protection investigations, an independent reviewing officer must agree with the decision if an investigation does not proceed to a child protection conference. However, this does not happen in cases where the requirement for a child protection investigation was not recognised or in those where the investigation process has not been correctly followed, leaving a gap in the additional oversight provided.

30. An increasing number of children are subject to a child protection investigation. The authority's data shows an increase of 27% in the last three months to July 2015. This has not resulted in a corresponding increase in the number of children subject to a child protection plan. Based on the authority's data, this figure increased by just over 4% in the same period. Due to the unreliability of the authority's performance data, it is not possible to be confident in the accuracy of these figures. The local authority cannot know, for example if the increase in investigations is due to more taking place or how they are recorded on the system. The local authority recently audited a sample of child protection investigations that did not result in children becoming subject to a plan. It found that in a high number of cases children

had become looked after following the investigation and a plan was not therefore necessary to safeguard their welfare. A small sample of cases seen by inspectors replicated these findings.

31. The quality of assessments is variable, something the local authority recognises from its own practice audits. Over 50% of assessments seen by inspectors were not good, as they did not sufficiently consider key risk factors, especially those arising from domestic abuse or the family's history. In poor-quality examples, the analysis did no more than list concerns without consideration of the context to establish risk and protective factors for an individual child. As a result, opportunities to reduce or manage risk more effectively were not identified. In the majority of cases, children are seen and spoken to alone. However, the resulting assessments did not routinely reflect their wishes and feelings. Assessments generally give poor consideration to issues of diversity or culture. The majority are completed without reference to research or how significant factors impact on the day-to-day lives of children and families. Some assessments did demonstrate good practice relating to a specific aspect, such as the inclusion of the father in the assessment or the recognition of factors suggestive of child sexual exploitation.

32. The local authority does not routinely set timescales for the completion of assessments that reflect the complexity of the presenting issues in individual cases or the child's needs. Instead, a standard timescale of 45 working days is used. Local authority figures for July 2015 (most recent data available) shows that performance against this measure differs significantly across offices, ranging from 76% to 97% being completed within 45 days. In July 2015, 322 assessments had taken over 45 days and were not yet completed. Where inspectors saw delays, social workers identified pressure of work, high caseloads and a lack of administrative support as contributory factors to the poor timeliness of assessments. There are long-standing difficulties in uploading completed assessments onto the electronic recording system, though this problem is now reducing from 759 outstanding in September 2014 to 419 in September 2015. In cases seen by inspectors, failure to complete assessments within a child's timescales did not lead to a delay in providing services. However, poorer-quality assessments that did not cover the child's full history or identify all risks led to risk not being managed effectively in over half of the cases tracked in the inspection.

33. Social workers told inspectors they feel supported by line managers and receive regular supervision. Line managers routinely record discussions and decisions regarding individual cases. While supervision and case records identify future actions, many give no rationale. As a result, in cases where an inappropriate decision or action had been taken, it was not possible to identify what the manager had considered in reaching their conclusions.

34. When risk is identified, this is frequently managed by making a written agreement or contract of expectations with the family. This is common practice in both child protection and child in need cases. For children subject

to a child protection plan and managed under the public law outline, social workers and managers actively monitored how effective these agreements were in reducing risk in all but one case seen. However, in cases that have not yet met this threshold or are considered as child in need cases, this was not the case. This was of particular concern in cases that featured domestic abuse, where there is an expectation that the partner, who is the victim, will be able to oversee the safety of the children without sufficient independent checking and monitoring of this arrangement by children's social care. In two cases seen by inspectors this practice led to one child being left at potential risk and another suffering harm.

35. Following the completion of an assessment by a qualified social worker identifying the child as a child in need, cases transfer to a family support worker (FSW). FSWs undertake their own child in need reviews and meetings and update the child in need plan, even when there are risk factors that have been identified. Inspectors saw six cases where the decision to manage the case at the child in need rather than child protection level was inappropriate. Social workers do not monitor the effectiveness of the plans or coordinate the work of FSWs. Inspectors saw examples of good practice by FSWs in engaging and supporting families. FSW managers are qualified social workers but do not adequately monitor the volume and quality of work with children in need as not all FSWs receive regular supervision. In some cases, inappropriate decision-making led to cases being stepped down from a child in need case or closed before all risks and needs had been explored.

36. The vast majority of written child in need and child protection plans are not robust enough to support good-quality interventions with children and families. The local authority has identified through its own case audits the poor quality of plans as an area for improvement. The planning template on the electronic recording system used by workers is not child- or family-friendly and many plans lack timescales for actions. This means that actions have to be monitored by other means, for example through conference recommendations or in supervision. Plans do not routinely make it clear to families what needs to change as opposed to what they need to do. This makes success in reducing risk difficult to measure. The lack of specific, measurable, realistic targets in plans limits managers' ability to monitor effectively and take timely action to reduce delay. At the end of a child protection plan, cases are often stepped down and managed at the child in need level.

37. Multi-agency risk assessment conferences (MARAC) appropriately consider cases of high-risk domestic abuse. Police act as the lead coordinating agency for all meetings across Lancashire. Each district has a consistent chair, ensuring continuity. The local authority fully participates in conferences identifying children potentially at risk and intervening to protect them. However, few direct referrals come from children's social care, less than 1% since April 2015.

38. The local authority, supported by the Local Safeguarding Children Board (LSCB), has a strong focus on identifying and tackling child sexual exploitation. A range of actions have been taken to ensure that staff understand its significance and in the majority of assessments where children are at risk of or have experienced child sexual exploitation, this is identified and appropriate action taken to reduce risk. Specialist social workers in localities provide advice and support to social workers. Work has been successful in supporting victims. The police commented to inspectors that some cases would never have resulted in a successful prosecution without the high-quality support social workers gave children and their families.

39. Police and children's social care have identified that referral pathways need reviewing and strengthening in order to ensure there is a full picture of the extent of child sexual exploitation in Lancashire. Work has begun to consider this. Lancashire shares some of its dedicated child sexual exploitation services with two neighbouring local authorities. Data are collected for the whole police force area, rather than specifically for Lancashire. However, staff across agencies on the ground know the local hot spots for child sexual exploitation and the profiles of the children most at risk.

40. An experienced designated officer, supported by an experienced social worker, manages allegations against adults working with children. The designated officer is co-located with social care and the police, which enhances communications. Effective management systems track the progress of all cases from the point of initial consultation, ensuring that actions are completed promptly. While the number of allegations is high – 491 during 2014–15 – the local authority's own regional benchmarking shows that the referral rate of less than 19 cases per 10,000 of population is well within the range for North West authorities. Cases seen and discussed with inspectors demonstrated suitable decision-making.

41. The authority receives a referral from the police for all children reported missing from home and has commissioned an independent organisation to undertake return home interviews. Due to the poor quality of its data, the local authority relies on police data which includes neighbouring authorities. The local authority does not therefore have an accurate overview of numbers of children who go missing or trends within its own area. In the period September 2014 to March 2015, there were 234 episodes requiring a return home interview referred to the commissioned service that conducts return interviews for children not already known to social care. Return interviews were offered in all these cases. For children known to social care the family's allocated worker follows up a missing episode. The Head of Service is notified of all children missing for over 24 hours. While the local authority receives copies of the completed return home interviews, these are not always shared with the police. This reduces the police's ability to map this data with other intelligence to form a clearer picture of where children may be at risk of child sexual exploitation or exploited in other ways.

42. The authority has a coherent strategy to monitor children who miss education (CME). It places children who have not taken up a school place on the CME list and investigates their whereabouts by contacting a range of agencies, including other local authorities. At the time of the inspection, the authority was investigating 62 children who have not taken up their school places. It had identified and was actively monitoring seven children who were missing education. During the autumn term 2014–15, 86 children were missing from education. The figures for the spring and summer terms were 57 and 75 respectively. In all cases, the authority followed up and monitored to ensure risks were reduced. In the same year, 56 children moved abroad. The authority has investigated whether any of the children who moved abroad were at safeguarding risk and established they were not. However, recording of the details of these investigations is sometimes incomplete and does not reflect the quality of the work.

43. At the time of the inspection, 644 children were home educated. Managers do not analyse well information about the reasons parents educate their children at home. This means they are unable to identify and respond to any significant factors and limits their ability to identify any children with significant additional needs and offer appropriate support.

44. The local authority actively considers the risk of radicalisation, and gives regular briefings to social care staff and other agencies to raise awareness. The pan-Lancashire 'Channel' panel has been in operation since 2012, with representation from appropriate agencies. A senior manager from Lancashire who is the strategic lead for Prevent and child sexual exploitation within the local authority attends the current Channel panel, which meets bi-monthly. This ensures effective links and information-sharing between children's services and Channel in respect of young people at risk of radicalisation. Agencies report good partnership working across the area and growing professional confidence. The LSCB e-safety group has advocated self-review in schools of the Prevent agenda, and online workshops are available to support British values in the classroom. The local authority provides good support and guidance for partners on safeguarding, radicalisation and the Prevent agenda. Its staff respond well to specific enquiries from partners, for example when schools need advice on complex radicalisation issues.

45. The local authority has identified prevention and response to neglect as a priority, based on an understanding of the level of need within the county and an unexpected decline in the rate of children subject to a child protection plan under the category of neglect. From March 2014 to March 2015, this fell from 18 to 13 per 10,000 population. Training and briefings are now available to support professionals and identification of neglect is improving, with an increasing number of children subject to a child protection plan (from 13 to 15 per 10,000 population) by June 2015. This figure is still below comparable authorities or England averages.

46. The authority is working to promote understanding of the impact of domestic abuse, parental substance misuse and parental mental health. The need for better recognition of these factors featured in the learning from a recent serious case review that has been shared with staff. How prevalence information is collected and used to inform and evaluate service provision varies, but is at an early stage overall. It is collected for those receiving early help services and considered when looking at impact. Impact for families referred to children's social care is monitored at the individual case level. Information is collected on the number of cases referred to the MASH (505 out of 3,059 last year) involving domestic abuse but not regarding referrals to the CART, which handles approximately 1,000 referrals per month. The prevalence of these issues is not known for open cases but is monitored for those children subject to a child protection plan. At 31 July 2015, this shows that of children subject to a plan, 40% have a parent with a substance misuse problem (alcohol or drugs), 42% have a parent with a mental health problem and 23% (226 children) have a parent with both. Engagement by services to support parents with domestic abuse, drug abuse or mental health issues was good when the need for this was clear within the assessment, with agencies then attending core groups. This was not the case for assessments seen that did not sufficiently consider the parents' needs; in these cases not all key agencies regularly attended core groups limiting the impact of the plan.

47. The authority assesses all 16 and 17-year-olds who present as homeless. In cases seen, young people who cannot return home are informed of their right to become looked after and suitable accommodation is found for them. The authority does not hold general data on the number of 16–17-year-olds who present as homeless, only those who then become accommodated. It is therefore difficult for the authority to know what the need is and to ensure that sufficient accommodation is available for these young people. Although only used as a last resort, in the last 12 months three young people have been placed in bed and breakfast accommodation. This is not appropriate.

48. The prevalence of children at risk of female genital mutilation is not yet understood by the local authority and partner agencies. During the inspection, work was being undertaken based on the release of health data on 1 October 2015 to map more accurately areas that may present a concern. The authority and other agencies are working to raise awareness among professionals. In the last 12 months no cases were referred to children's social care where female genital mutilation was suspected.

49. The local authority and the police work together to manage cases of forced marriage and honour-based violence. In two of the three cases seen by inspectors, the responses were insufficient, with no acknowledgement that the young people involved were also children who may be in need of protection. In both cases, clear risk to the young person was identified in the initial referral. In one case, the police's actions had protected the young person; in the second, it was unclear if any action had been taken to consider or reduce risk.

50. At the time of the inspection, 32 children were identified as living in private fostering arrangements across Lancashire. The authority has undertaken a programme of awareness-raising. However, this figure is low, given the authority's size. The local authority is aware it has failed to meet basic statutory requirements for the majority of children in this highly vulnerable group. Social workers responsible for these cases lack specialist knowledge. The quality of the assessments undertaken is acknowledged by the authority to be variable as they do not always sufficiently consider the carers' ability to meet the child's needs. Appropriate checks on adults in households offering private fostering were often delayed, leaving children in potentially vulnerable situations. A specific audit conducted by the local authority identified that 28% of children were not visited within the first seven days. Although for the first 12 months 91% of cases were visited within the timescales required under statutory guidance, after this period the only performance reports available (which may be inaccurate because of the local authority's poor-quality data) suggested that only 33% of children are visited within requirements.

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

**Summary**

Services for looked after children are not yet good. Children do not receive up-to-date assessments of their needs to inform their plans and ensure that the work that is done with them is relevant to their current circumstances. Care plans lack clarity and detail about children's arrangements, plans for their future and timescales for completion of agreed actions. Permanence is not promoted consistently for all looked after children.

Independent Reviewing Officers (IROs) do not consistently monitor children's cases to ensure they are receiving the services they need and that their plans are progressing as agreed.

Children are seen regularly by their social workers, they are listened to, including when they complain, and their views are recorded. Placement stability is good but the authority has not achieved its targets to improve the range of placements and services in the area to ensure children are in the most suitable placements. When children go missing they receive timely return interviews and there is a good level of awareness of the risks they face, including child sexual exploitation.

Looked after children do not achieve well in education. Too many have no personal education plan and this lack of planning for their education and training continues as they get older. Access to specialist services, such as child and adolescent mental health services (CAMHS), also varies across the county but generally takes too long.

Services for children in need of adoption are improving and they receive good-quality support post-adoption. Many still wait too long for permanence and do not receive timely help to understand their past experiences. There is a lack of strategic oversight of adoption. Previous targets, rather than the local authority's analysis of current need, inform recruitment of both adopters and foster carers.

Care leavers are too often poorly supported by the local authority. Too many are not in touch with their support workers. Pathway plans do not ensure that important aspects of young people's welfare are promoted. The number of care leavers not in education, employment or training is too high. The local authority's understanding of the experience of care leavers is too limited due to poor data.

**Inspection findings**

51. The number of children looked after in Lancashire in March 2015 was 1,610, which was 66 children per 10,000. This is lower than similar local authorities (67/10,000) but higher than the national average at 60/10,000. The reasons

for this are not well understood by the authority due to poor local data and information systems. The council's explanation is that a robust response to neglect and limited success in returning children to their parents' care are likely to be contributing to the relatively high number of looked after children.

52. In cases seen by inspectors where the decision to look after the child was taken recently, this decision was appropriate and timely. However, inspectors found that too many looked after children did not have an up-to-date assessment of their needs to inform plans and decisions at any stage. The local authority has introduced a requirement that looked after children's assessments should be updated every year, but monitoring shows that this is achieved in only 55% of cases. Equality and diversity were not addressed well in children's plans and records, a small number even lacking a record of the child's ethnicity.

53. Social workers visit children regularly, see them alone where appropriate and record their views in case files. Managers read children's files regularly and record when they have discussed cases, but these records are not used well to improve planning or to focus and direct the involvement of the social worker. Too many records are descriptive and lack analysis and direction.

54. The standard of care planning for looked after children is inconsistent and is not sufficiently robust. In the majority of cases seen during tracking and sampling, children's plans did not contain enough detail. In 10 of 15 cases looked at in detail by inspectors, care plans were found to require improvement and this was reflected in further cases sampled during the inspection. Common concerns identified by inspectors included failure to specify what needed to be done and by whom and a lack of timescales for elements of the plan to be completed. Plans were also adversely affected by the lack of chronologies in children's case files, which meant that the historical context of the plan was missing.

55. The authority's performance in achieving permanence for children looked after is too variable. The local authority does not monitor this area of practice as part of its monthly performance reports and the IRO service does not collect information on how well permanence is being promoted at children's review meetings or through wider monitoring by IROs. The authority has introduced a panel, chaired by a senior manager, to agree permanence arrangements for looked after children, but this started during the month of the inspection so it is not possible to measure its impact. In eight of 18 sampled cases, opportunities to meet children's longer-term needs and achieve permanence through robust care planning were missed.

56. Lancashire cannot be confident that there is timely consideration of adoption for all children who are unable to return home to their birth families because the strategic oversight of the service is not effective. Senior managers are not easily able to identify or address drift, due to the absence of a centralised permanence monitoring system to track children from the moment they enter

care until they are adopted. Inspectors saw good practice for some children but in other cases decisions for a child to become looked after had not been taken early enough. Independent reviewing officers do not always consider permanence for children at their second looked after children review.

57. The local authority promotes and supports special guardianship orders (SGOs) well as a mechanism for achieving permanence for children. During 2014–15, 17% of children who ceased being looked after were made subject to SGOs, which is considerably higher than the England average at 11% and more than the number of children in Lancashire who left care as a result of adoption (16%).

58. IROs do not monitor children's cases frequently enough or in sufficient detail. Inspectors saw evidence of oversight and challenge in some children's cases and the authority's own monitoring shows that there has been more activity in this area recently: there were 500 IRO recordings in children's files made in May 2015. Children's review meetings were held on time in 97% of cases in July 2015 but the authority's performance in this area has fluctuated and the annual rate for 2014–15 was 86%. The local authority acknowledges that IROs' caseloads are too high: some IROs in Lancashire hold more than 130 cases compared with the recommended national level of between 50 and 70. Three IRO posts were vacant at the time of the inspection and the authority was having difficulty recruiting to them. Overall performance in this service has improved but is still not meeting the authority's own targets and improvement is further hampered by the lack of timely information available to IRO managers.

59. Social workers consider placement with family members in appropriate cases. The consistency and quality of viability assessments has improved as a result of oversight from the principal social worker. This was confirmed in feedback from the the Children and Family Court Advisory and Support Service (Cafcass) and the courts. Placement with parents and returning children to their parents' care while still looked after are also considered in appropriate cases. In the eight cases seen by inspectors where children had either remained with or returned to parents during or following care proceedings, inspectors found that the placements were appropriate and in line with the children's needs. However, in too many cases there was insufficient evidence that a thorough assessment had been undertaken to inform the decision. All case files seen included references to home placement agreements (HPA), but these were not evident in the majority of the files (six out of eight) and the plan had not been subject to robust enough review. In one case, the IRO raised a starred recommendation because there had been delay in progressing the discharge of the care order and the parents had never signed the agreement. The HPAs which were seen by inspectors (two) were suitably detailed and informed and supported the plan well.

60. In three of four sampled cases where children remained with their parents during court proceedings, inspectors found that social workers had not

completed the authority's home placement agreement. In all four cases the agreements had not been subject to robust review.

61. An effective duty process identifies foster care or children's home placements for children who need them, taking into account factors such as the child's assessed needs, contact, proximity to the child's school and family and the needs of any other children and young people in the placement. Placement requests seen during sampling were of variable quality but the majority were good and the children and young people placed appropriately. In 2014-15, 19 children who the local authority had identified should have been placed together with brothers or sisters were separated. This represents more than 10% of the children who needed placements with siblings and demonstrates that the authority does not yet have sufficient placements available to meet all children's needs.

62. The geographical area covered by the local authority is large but it does not measure its performance in ensuring that children are placed close to their homes and schools within the county. It cannot be certain how many have had to change school or are placed at a distance from their family and friends.

63. Young people who are placed in other local authority areas receive regular visits and telephone contact from their social workers, and their contact arrangements and leisure activities are supported. Young people placed out of area were thriving in their placements, although some had experienced initial delays in their health or educational needs being met.

64. Placement stability is promoted well by the authority. Only 9% of children looked after for 12 months or more moved more than three times in 2014–15, compared with 11% for comparable authorities and 11% for England. The proportion who remained in the same placement for over two years was 73% compared with 65% and 67% respectively.

65. Children's contact with their parents and siblings was considered well and supported by the local authority in the cases seen by inspectors. Children and young people were also helped to enjoy a range of interests and activities. This was confirmed in sampled cases and by foster carers who receive help and encouragement to support children in their interests and activities and are also supported to promote and contribute to contact arrangements.

66. In children's cases which are subject to court proceedings or to the pre–proceedings process, planning is more timely and thorough than care planning and practice in other cases. A care planning protocol sets out the process and timescales to be followed by social workers and managers in these cases. This supports effective planning and includes prompt completion of assessments to ensure children's cases progress through the court process. Data from Cafcass at the time of the inspection show that timescales for court proceedings were 27 weeks on average. While this is slightly above the expected timescale of 26

weeks, this represents significant improvement compared with an average of 41 weeks in 2012–13.

67. The authority has positive relationships with both Cafcass and the courts based on good levels of communication and cooperation. Cases which come to court are well prepared and the authority ensures that social work and other assessments are completed promptly. Communication between the IROs and Cafcass has improved over recent months so that care planning and court proceedings are better informed and more aligned. The local authority is responsive and constructive in its engagement with the courts and local court users' forums.

68. However, the local authority does not have a mechanism for county-wide management oversight of cases subject to the Public Law Outline. A panel which served this purpose and a specific post to ensure these cases were managed effectively from the outset were discontinued in September 2015. The authority now records the progress of individual cases but there is no overall mechanism to co-ordinate and promote consistent standards of practice, consistent thresholds and timeliness.

69. According to the local authority's own unvalidated data it has narrowed the attainment gap between looked after children and all children in Lancashire. If the data are accurate, the attainments of looked after children at Key Stage 1 in reading, writing and mathematics at level 2 improved in 2014–15 from the previous year by 10 percentage points. The attainment of looked after children remains 15 percentage points lower than the attainment of all children in the authority.

70. The local authority's own unvalidated data for 2014 indicate that the proportion of looked after children who attained level 4 at Key Stage 2 in reading, writing and mathematics combined was low at 49%. This is around 30 percentage points below the level for all children in Lancashire.

71. In 2014–15, 14% of looked after children successfully gaining at least five A* to C GCSE grades including English and mathematics, which was an improvement from the previous year. The proportion that succeeds is poor at over 40 percentage points below the rate for all children in Lancashire.

72. Local authority figures indicate last year's attendance rate for looked after children at primary school was high at 97% Attendance of secondary school pupils at 86% is significantly lower and requires improvement. Persistent absenteeism at 4% in 2013–14 is marginally below the average rate for looked after children in England, but is reported by the local authority to be increasing.

73. Too many looked after children lack an up-to-date personal education plan (PEP) The quality of completed PEPs is poor overall. Targets are too broad, not measurable and do not monitor children's progress. The head of the

virtual school has introduced a provision map which includes a better set of educational and attendance targets, but this is not yet in place for all children. The views of children are often not recorded in the PEPs or provision maps.

74. Approximately 75% of looked after children attend good or better schools. The others attend schools which meet their circumstances. For example, they attend schools close to their foster carers. Around 10% of children (117) are placed in schools outside the local authority. The authority's systems for monitoring the relative performance of children looked after in different schools are under-developed. As a result, the authority does not know whether there are any performance gaps.

75. Virtual school staff monitor the performance of looked after children through a well-considered risk-based system that identifies some children who are at risk of poor performance and triggers intervention when low performance is identified. However, the pace of interventions is not always fast enough. Staff do not have a reliable system to compare the performance of the looked after children who study within and outside the authority. The virtual school does not monitor or support the educational progress of looked after children post-16. This is a significant gap in provision.

76. There are strong indications that as a result of good partnership working, including a number of social workers being based in schools, the attendance rates and behaviour of vulnerable children, including looked after children, have improved. Within the last two years no looked after children have been permanently excluded from schools, and a smaller proportion of looked after children have had at least one fixed-term exclusion than similar groups in England.

77. All 298 children receiving alternative provision receive effective support from pupil referral units and are progressing in line with individual targets. The 17 children who receive less than 15 hours of education per week due to physical or mental health issues, or extreme views, have clear plans to increase their educational hours.

78. According to the local authority's unvalidated data at the time of the inspection, over three quarters (79%) of looked after children and young people are placed within the local authority. Plans to make further improvements to ensure that provision and commissioning offer maximum choice of placements and the best possible match to children's assessed needs have not made sufficient progress. The council's sufficiency strategy is not supported by accurate and up-to-date information about current and future needs. In addition, too many targets and deadlines for the development of the strategy have been missed. This means that children and young people cannot be satisfied that the authority has worked effectively to deliver the maximum choice of high-quality placements to meet their needs.

79. Foster carer and adopter recruitment are not ambitious and targets have been generated based on the council's estimate of what it can achieve rather than the level of need. The current target of 75 new foster carers to be recruited in 12 months is the same as the target for the previous year and does not take into account the net loss of 32 foster carers during 2014–15.

80. Foster carers spoken to by inspectors are positive about the supervision, training and support they receive from the local authority. Known information about children is shared with them before children are placed and they are fully involved and consulted about children's plans. This means that they feel valued. Foster carers are reviewed regularly but some of the reviews seen by inspectors lacked detail and rigour.

81. The authority has a number of specialist foster carers who work with young people with mental health or substance misuse problems or provide mother and baby placements. These carers also provide help and advice to other carers. Inspectors saw two cases where mother and baby foster carers had worked effectively and skilfully to help assess risk, encourage parenting skills and develop appropriate plans for children.

82. Looked after children and care leavers are not well informed about their rights and entitlements. However, through its formal mechanisms, the local authority ensures looked after children have a voice. There is an active and well established children in care council (CICC) which is well integrated into the Corporate Parenting Board. The CICC was instrumental in the design of consultation documents for looked after children reviews and has contributed to the recruitment and selection of senior staff in the authority and the development of a young inspectors' scheme.

83. Looked after children are supported by an advocacy service from an independent provider. This is available to all children who wish to raise a specific issue but was previously routinely offered to all looked after children. Inspectors saw a small number of cases where children had been effectively supported by an advocate to raise issues that were important to them.

84. The authority's promotion of the health of looked after children varies across the county and is not consistently good. Inspectors found that it was difficult, and in some cases impossible, to locate health information on children's case files even when accompanied by the case-holding social worker. At the time of the inspection the percentage of children who had received a health assessment in time was 84% and this improved for children who have been looked after for 12 months to 89%. Timeliness of dental visits for all looked after children is 78% and for children looked after for over 12 months declines to 72%. The rate of up-to-date immunisations for all looked after children is 78% and for children looked after for more than 12 months is 88%. Each of the three areas in the authority provides trained community paediatricians to undertake health assessments.

85. For children who require more specialist help, access to clinical psychologists and CAMHS varies too widely across the county, which means that where a child lives affects their access to services. Children in East Lancashire wait on average less than six weeks between referral to CAMHS and assessment in comparison with an average of: 30 weeks in Chorley and South Ribble; 22 weeks in West Lancashire; 20 weeks in Preston; 18 weeks in Lancaster and Morecambe and 16 weeks in Wyre and Fylde. As a result of these historical problems, the council has developed Supporting Carers and Young People Together (SCAYT+), a specialist team of two clinical psychologists and 11 specialist workers to promote the emotional health and well-being of looked after children. In tracked and sampled cases inspectors found that this service was accessible, timely and valued by staff, parents and carers who benefited from the support and consultation they received.

86. Social workers and managers are aware of the potential risks involved when young people go missing. Children and young people who had been missing from care were offered return interviews within 72 hours of their return in the majority of cases seen. However, these interviews were of variable quality and the authority does not systematically monitor their quality. When young people go missing repeatedly, their cases are reviewed by managers, which is positive, but the authority does not collate the information gained to inform future improvements in practice.

87. In most cases seen, risks to children and young people from child sexual exploitation, alcohol and substance misuse were appropriately identified and relevant help offered. Children have access to a range of services, which include the SCAYT+ service, CAMHS and commissioned services. Inspectors saw evidence of the effective use and accessibility of these services in sampled and tracked cases. If there is no relevant service or a risk of unreasonable delay, senior managers approve bespoke services from a devolved budget.

**The graded judgment for adoption performance is that it requires improvement**

88. The number of children adopted has risen significantly over the last three years, with 121 adoptions in 2014–15 compared with 85 the previous year. The data shows that there are fewer children waiting for adoption than a year ago and the trend for 2015 is set to continue. In 2014, Lancashire had 16% of children leave care as a result of adoption. This was below the national average of 17%. A targeted focus on children who had waited a long time for permanency due to the complexity of their circumstances led to 36 children placed for adoption or in permanent placements during 2014–15. The local authority has not undertaken an analysis of the process, which is a missed opportunity to identify what lessons could be learned to prevent future delays for children.

89. It takes too long for children in Lancashire to move in with an adoptive family after becoming looked after. The latest published figures (2011–14) show the average time between a child entering care and moving in with their adoptive family was 779 days. Although this was a slight improvement on the figure for 2010–13 (786 days), it is significantly longer than the national average (628 days) and the national target of 547 days. Local, unvalidated, data suggest that there is an improving trend, with the single-year figure reducing from 875 days in 2012–13 to 609 days in 2014–15.

90. The most recent published data for 2011–14 showed the average number of days between receiving court authority to place a child for adoption and the authority deciding on a match to an adoptive family was 272 days, an increase of 18 days when compared with the 2010–13 period (254 days). Local data for 2012–15 show a further increase of 17 days to 289. Local year-on-year data show a slight improvement from 315 days in 2013–14 to 266 days for 2014–15. Although local predicted figures for 2012–15 show a further deterioration to 289 days, the in-year performance for children where the 'should be placed for adoption' decisions have been made since April 2015 is 115 days, which represents considerable improvement.

91. The proportion of children from Lancashire who wait less than 18 months between entering care and moving in with their adoptive family is also improving, from 36% in 2011–14 to 46% in 2012–15.

92. The local authority does not have an up-to-date adoption recruitment strategy based on the current profile of children needing adoption or an analysis of predicted need. A planned media campaign aims to recruit 75 adopters, based on previous recruitment figures. There has been no analysis of or targets set for the number of placements required for children who need to live with their brothers and sisters, are older or who have complex needs. The absence of an effective permanence monitoring system hampers the local authority's ability to focus on targeted recruitment to meet the needs of Lancashire children.

93. Prospective adopter reports (PARs) seen were comprehensive and thorough, with all relevant checks being completed prior to an assessment commencing. Effective quality assurance by the agency decision-maker (ADM) and panel adviser ensures the vast majority of cases have sufficient information for the panel to make a decision when they are first presented.

94. Some 20 children have benefited from concurrent placements which have provided them with continuity during court proceedings and resulted in an outcome of adoption. A further seven concurrent carers are either at the assessment or approval stage. Although not quite as advanced, a more recent focus on fostering to adopt has led to one adoption placement. Training and preparation sessions now present additional information about fostering to adopt, in order to stimulate additional interest. This has led to the commencement of a further three assessments.

95. Lancashire refers adopters appropriately to the National Adoption Register and the decision to do so was timely in cases seen by inspectors. Of 34 adopters without a placement, 32 have potential matches identified. At the time of the inspection, 48 children with an adoption plan had not yet been matched and sufficiency of placements remains significantly outstripped by need.

96. Placement and permanence coordinators offer additional support to social workers and managers in locality teams to assist with the identification of children where there could be a potential adoption plan. Family-finding commences as soon as the case transfers to the Children Awaiting Adoption Team, following the ADM decision. There is a coordinated use of in-house placements, a regional consortium, Adoption 22 and voluntary agencies. The authority has taken part in three adoption activity days. These actions, while resulting in positive outcomes for some individual children, have not yet significantly improved performance overall.

97. The data show a rise in the numbers of sibling groups placed for adoption together from 15 in 2013–14 to 19 in 2014–15 and 11 so far this year. Formal together or apart assessments are only undertaken, however, when separation of siblings is being considered. This is a missed opportunity to ensure that all siblings have their needs met and promoted within their placements. The quality of the assessments seen was inconsistent, with the majority not offering an evaluation of children's individual needs and views.

98. Child permanence reports (CPRs) are on the whole comprehensive, child focused and with a detailed understanding of the child's journey. Before making a decision that children should be placed for adoption, the ADM robustly considers all alternatives through face-to-face recorded meetings with the social worker and the local authority legal adviser. These meetings ensure a thorough exploration of the care planning. Feedback to staff from the ADM and the panel adviser has assisted in improving the quality of the reports presented.

99. IROs appropriately review children's plans to consider if adoption remains the right plan for them. When the decision is changed, revocations of placement orders are given appropriate priority and this is scrutinised effectively by the ADM. At the time of the inspection 51 children had had their plan changed and were in various stages of the process of having their placement orders revoked. Although in a small number of cases seen there was delay in progressing these plans, the decision to change the plan was appropriate in all cases.

100. The Adoption Panel chair is suitably qualified and experienced for the role. There is a central list of panel members made up of social workers and independent people. Further work is in progress, to develop the diversity of the panel and to include the voice of the child. There are three adoption panels per month, which reflects the significant activity level. Panel minutes are thorough and produced promptly. They do not always indicate reasons for

delay when assessments do not meet identified time targets, making it difficult for the service to identify and address any recurring issues.

101. The adoption panel annual report process does not meet National Minimum Standards, with only one produced in the last 18 months. The panel has not formally approved the recently completed 2014–15 report. The report does not provide an overview of current practice issues and focuses mainly on data and performance information from previous years. This limits its usefulness in driving up performance. The service recognises that this is a deficit that requires addressing.

102. Lancashire successfully challenged a court's decision, which led to a legal finding in relation to the expedient filing of adoption applications where children are in concurrent placements. It has paved the way for swifter adoption for children who are already benefiting from concurrency and demonstrates the local authority's commitment to challenging barriers to ensuring adoption is achieved without unnecessary delay.

103. Previous inspections and reviews have identified life story work as an area for improvement. Practice remains variable, both in ensuring children receive sensitive help to understand their pasts at a time that is right for them and in ensuring they have a life story book. Lancashire has recently targeted a backlog in providing children with life story books, but at the time of the inspection 18 children who have already been adopted (some from 2010) still did not have one. A recently developed tracking system will assist children with an adoption plan to receive timely life story work and books when this is an identified need. Looked after children for whom adoption is not the plan do not yet benefit from the same level of scrutiny. Life story books seen were of good quality for the most part, although a small number were not sufficiently personalised to the individual child. Later-life letters were not available on the files of two out of three recently adopted children. This does not meet the local authority's own standards or ensure that children have access to them in the future.

104. Post-adoption support is a strength, with 206 families receiving assessment support packages in 2014–15. In addition, there are 774 adoptive families who access the service on an informal basis via support groups, training, activities and events. A duty system and advice line along with a good range of support services were highly regarded by the adopters spoken to by inspectors. The authority has used the post-adoption support fund appropriately to secure funding for more specialist and bespoke support packages such as play therapy, psychological assessments and parenting programmes. The service has good links with the emotional and mental health service, which offers timely input for adopted children and their families who need assistance with emotional or behavioural issues. The numbers of adoption disruptions are low.

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

105. Care leavers spoken to by inspectors lack confidence in the local authority as a corporate parent. The local authority has not consistently implemented procedures and policies regarding entitlements. As a result, care leavers see themselves as subject to arbitrary and inconsistent decisions from social workers, personal advisors and managers regarding their financial entitlements, including when these are received. One care leaver said: 'if Lancashire is our parent we should all be in care'. Care leavers report the quality and quantity of support offered to them by personal advisors as highly variable, from very good to minimal, with many personal advisors offering too little support in achieving independence. Inspectors saw too many cases which supported this view and where support to care leavers is untimely or insufficient. There was no evidence in any of 17 care leavers' records seen of a systematic approach to preparation for independence. Where this is referred to in pathway plans, the need is sometimes noted but without a plan to address it.

106. According to data supplied to inspectors, the local authority was not in touch with 40 care leavers. Some of these are likely to be highly vulnerable. While some personal advisers make strenuous efforts to establish and maintain contact with care leavers, too often they do not receive effective support until they reach crisis point. A commissioned service offering 24/7 support in the Preston area recently alerted the local authority to the increasing numbers of young people being evicted due to financial difficulties.

107. In cases seen, efforts to keep in touch with care leavers who had disengaged were insufficiently rigorous, often relying on them responding to text messages from staff whom they had never met. In some cases the local authority assessed the care leaver as being in touch when in reality this contact was insufficient to meet the needs of the young person.

108. In many other cases seen by inspectors, where the care leaver is in contact with the local authority there is an over-reliance on staff in accommodation settings fulfilling the role of local authority staff. Inspectors saw examples of a lack of responsiveness to requests from accommodation providers where care leavers were having difficulties or needed a personal advisor allocated. The workload of personal advisers who support care leavers is broad; they have mixed caseloads, including children in need and child protection. Support staff and managers reported that this breadth of workload is a barrier to prioritising the needs of care leavers. Personal advisors and social workers do not always have the specialist knowledge needed to ensure they record data accurately or fulfil all of their statutory responsibilities. It is highly unlikely, for example, that none of the care leavers reported as attending university live in houses of multiple occupancy. Some young people recorded as 'not in touch' were active

cases to adult services and inspectors saw one case where a worker intended to close a case of a relevant care leaver contrary to her legal entitlements.

109. Personal advisors and social workers do not sufficiently engage young people in drawing up their pathway plans and care leavers spoken to by inspectors place little value on them. They are too often statements of the care leaver's situation rather than a key tool in planning their future. Plans lack reference to some key issues for care leavers, such as whether they have a curriculum vitae. Inspectors saw examples where pathway plans were over-optimistic about whether care leavers' emotional needs were being met. Plans usually lack timescales. Reviews are not always timely and there is insufficient rigorous review of the progress of care leavers towards the aims. Personal advisors carry out some pathway plan reviews which do not benefit from external independent challenge. Pathway plans are not referred to in supervision other than that they need completing, so there is insufficient evidence of managerial oversight of the plan. The local authority has no data on Pathway plan completion, indicating a lack of focus on ensuring plans for care leavers progress as they should.

110. Preparation for independence is unsystematic and dependent on the setting where the young person is living. Too often, pathway plans do not include evidence-based analysis of the individual care leaver's strengths and areas for development to achieve independence, such as budgeting. Care leavers described how plans would often note a problem but not provide a solution. Inspectors saw examples of plans which exemplified this deficit. Plans for future moves, for example towards greater independence, are therefore often not based on thorough analysis of individual needs and strengths.

111. At the time of the inspection, of 754 care leavers, 11 were homeless, there were five whose residence was not known, eight were in foyers and one was in emergency accommodation. There were 24 relevant and former relevant young people in custody and 18 in other accommodation. According to the data supplied by the local authority, it places a low number of care leavers in bed and breakfast accommodation when in need of emergency accommodation. When the local authority places care leavers in emergency accommodation there are, in some cases, practice deficits, such as in the frequency of visits by local authority staff. No risk assessments were seen for care leavers moving into foyers and other provision where there are older adults. One case showed a lack of response to reports of threats to, and theft from, a care leaver in a foyer. When care leavers then move on to long-term accommodation, they said that they generally felt safe and that, when they moved in, properties were well maintained.

112. The authority plans to join a regional collaborative arrangement for care leaver accommodation in the near future and is aware that the current arrangements are unsatisfactory. Staying Put agreements are formalised too late in some cases, including after care leavers have turned 18, causing unnecessary anxiety and uncertainty for the young person and their carers.

Some foster carers report financial concerns if they enter Staying Put arrangements and inspectors were told by several sources that this was a disincentive. Care leavers living in Staying Put arrangements were clearly benefiting, and their outcomes were good. One care leaver was able to return to a Staying Put placement when it became apparent that greater independence was not right at that time. For another care leaver who was with the same foster carers for six years, and remained with them after 18 through Staying Put, education and leisure progress and outcomes are very positive.

113. According to the local authority, 94% of young people in care at 16 go on to appropriate education, employment and training options. However, of care leavers aged 19–21, only 47% are still in education, employment or training, which is too low. Based on the local authority's data, at the time of the inspection there were 42 care leavers studying in universities and who were supported with the cost of their education, but the local authority does not collect data on how many successfully complete their courses each year. The local authority does not, at this time, have sufficient analysis of the reasons why so many young people are no longer in education, employment or training post-19, such as the drop-out rate from further or higher education. The virtual school does not offer young people any support to remain in or re-engage with education or training post-16, which is a vital time of transition for many young people. The local authority does not keep records of the numbers of apprenticeships it provides to care leavers or know how many care leavers it employs. This lack of knowledge and rigour does not demonstrate committed corporate parenting to young people and can give them the impression that the local authority does not care what happens to them after they leave school. Care leavers who do remain in higher education receive appropriate support with accommodation during vacations.

114. The local authority does not have the essential up-to-date data it needs regarding the location and suitability of care leavers' accommodation, whether personal advisors are in touch with them, and whether care leavers are in education, employment or training. As a result, it cannot measure its performance nor assure itself that care leavers' needs are being met. Data supplied by the local authority in this inspection showed numerous inaccuracies and contradictions. For instance, the local authority states that it does not know the residence of five care leavers but has graded this accommodation as suitable. Case sampling showed that the local authority was too often over-optimistic in judging itself in touch with care leavers when contact was too irregular for the young person's needs. The local authority does not, on a regular basis, monitor the data that it does have to gain an overview of the quality of provision. In June 2015, the Corporate Parenting Board was supplied with some data regarding care leavers but this related to the period up to September 2014 and so was not timely.

115. Almost all care leavers are registered with a doctor and most are registered with a dentist. Where care leavers are not registered with a dentist, there is

insufficient action to promote this. Looked after children nurses have helpfully negotiated that non-attendance for dental appointments does not result in immediate 'strike off' by the practice. There are a low number of cases seen where child sexual exploitation was identified as an issue for care leavers. In those cases, practice was effective in ensuring young people's safety.

116. The local authority addresses the diversity needs of care leavers with complex health needs well. Transition plans are appropriately structured around a county-wide pathway, which is implemented in a timely way. Planning was thorough in cases sampled. The local authority and partners attempt to offer care leavers accommodation in the areas of Lancashire they identify most strongly with, but are not always successful due to a limited range of accommodation in some parts of the county.

117. The local authority has provided the resources for some much needed service provision and is intending through new programmes to address key needs regarding accommodation, employment, education and training. These programmes are too recent to assess their impact but at this stage show evidence of good multi-agency working.

| Leadership, management and governance | Inadequate |
|---|---|

**Summary**

Leadership, management and governance are inadequate. Senior leaders have failed to take effective action to address weaknesses in systems and social work practice. This has led to shortfalls in services to vulnerable children and left some children and young people at risk. An inspection of safeguarding and looked after children in 2012 judged services to be good with some outstanding features. Since then, the standard of service has declined in all areas. Senior leaders have not been successful in maintaining the quality of services to children through periods of planned change and have failed to address shortfalls effectively where these have been identified.

Elected members and senior managers in the local authority have not rigorously challenged the poor performance management information they receive. Long-standing issues with data reliability have not yet been sufficiently addressed for them to be confident they have an accurate understanding of the services' strengths and weaknesses or to assure themselves children are safe. This lack of accurate data, combined with an absence of target-setting or rigorous analysis, means that the local authority does not fully understand its current performance and does not clearly communicate expectations of practice to staff. Senior leaders have not analysed findings from the local authority's audit activity effectively or developed clear plans to drive improvement.

Many staff undertaking complex work are newly qualified or have limited experience. Social workers feel supported by their line managers and receive regular supervision, but management oversight of casework is not effective in ensuring continuous improvement.

Senior leaders have failed to effectively scrutinise the provision for significant groups of vulnerable children. Children in need are not subject to sufficiently robust management oversight by qualified social work staff to ensure risk is identified and addressed. Care leavers do not consistently have access to support from staff with sufficient knowledge and experience, creating variability in the quality of service they receive.

The local authority has formed effective working relationships with partners on strategic boards, including the Local Safeguarding Children Board, Children's Trust, and Health and Wellbeing Board. Children's needs are duly considered and priorities across boards are appropriate and well aligned.

Participation of young people in a wide range of strategic and quality assurance activities is a strength.

## Inspection findings

118. Senior leaders of children's social care in Lancashire have not provided the service with sufficiently clear or robust leadership following a period of planned and significant change. They have not addressed deficiencies in a new electronic record system introduced in February 2014 that required significant additional inputting for staff. They did not ensure that all staff have the required skills to cover a generic caseload prior to the restructuring of social work teams in April 2015 or fully risk-assess any potential impact of the restructure. They have failed to understand fully the subsequent negative effects on the quality of service provided to children and young people. As a result, they have not ensured that the service delivered to children remains consistently safe and effective. Despite a wide range of activity by senior leaders to engage with staff, most workers in teams were unclear about the leadership structure beyond their locality area.

119. Key areas of the social work service delivered to children and young people are not subject to sufficient oversight by senior leaders to ensure the effective management of risk and assurance of quality. The arrangement for children in need to be allocated to support workers has not been supported by robust and effective arrangements to ensure oversight by qualified social workers or front-line managers and no regular scrutiny is undertaken by senior managers or leaders. As a result, inspectors saw many children in need who had ineffective care planning, with little oversight from qualified practitioners, which led in some cases to insufficient recognition and assessment of risk. The impact of decisions to allocate all care leavers to the same support workers across localities has also not been understood or addressed sufficiently by senior managers and has resulted in delivery of a poor-quality service to this group of young people. The local authority has commissioned an external agency to evaluate outcomes of current service delivery and identify any efficiencies. This work had not started at the time of the inspection.

120. The lack of effective and systematic performance monitoring is a significant weakness in Lancashire. The quality of performance information is poor as a result of the lack of accurate data contained within the electronic system. The performance information provided to inspectors was in many cases incomplete and inaccurate. Senior leaders were aware of the data problems but have not responded robustly enough to ensure they can manage services effectively. Despite on-going work since the implementation of the new system in February 2014, the issue has not yet been resolved.

121. The scrutiny and challenge undertaken by senior and political leaders are limited by the poor information they receive. They have not effectively ensured they have all the information they need to formulate an accurate understanding of the children's social work service or to enable them to assure themselves that children are safe. In the data they consider Lancashire's performance is compared with some national and regional

indicators, but the local authority does not set itself targets. It does not routinely analyse data to identify risk, nor includes commentaries that assist effective challenge and inform improvement.

122. Leaders supplement the data they receive by collecting 'soft information' through an open door policy, walking the floor, observations of practice and staff forums. While this information is important, it is not sufficient in itself. Middle and front-line managers have developed their own individual systems for monitoring performance in their locality. Although this enables some local management of performance, it does not compensate for the overall lack of accurate corporate data.

123. Lancashire completes substantial amounts of audit as part of its performance management framework, with over 600 children having their cases considered over the last 12 months. This is effective at identifying aspects of front-line social work practice that do not meet the required standards or require further improvement but does not analyse the impact of the poor practice seen nor consider sufficiently the risk this presents to children and young people.

124. Some poorer practice seen during inspection had also been identified through these audits. This had not resulted in clear action plans to drive improvement in the quality of the service that children and young people receive. While some learning from audits is communicated to staff through regular briefings provided to locality managers, this has not yet been effective in driving up performance. Presentation of the findings from audit work is not sufficiently clear or detailed, with judgements about 'good' and 'adequate' work often combined, preventing easy identification of practice where little evidence of 'good' has been seen. This grading system sets too low a benchmark and is not congruent with the local authority's aspiration to ensure all children receive a consistently good service.

125. Many of the deficits in practice identified in the local authority's audits and seen in this inspection, such as poor-quality planning or lack of consideration of history, are not included as areas for improvement in the local authority's self-assessment. As a stand-alone document, the self-assessment does not show that the local authority clearly understands its performance or that senior managers are sufficiently focused on all areas of concern.

126. The local authority has appropriate arrangements to discharge its statutory responsibilities. The roles of Director of Children's Services (DCS) and Deputy DCS are within the newly formed Startwell service, which brings together a range of children's services including social work, education and preventative and early help provision. The DCS and deputy regularly attend strategic groups such as the Local Safeguarding Children Board, Health and Wellbeing Board, Children's Trust and Corporate Parenting Board. They have effective working relationships with partners on these boards, which are well aligned in their strategic priorities.

127. The county council Children's Trust, revised in late 2014, has effective links with other strategic bodies, and appropriate representation from all partner agencies and the Local Safeguarding Children Board. The Children's Trust is the overarching board for the five local partnership boards that operate within Lancashire. The local boards provide an effective structure for partners to consider the priorities of the Children and Young People's Plan and how these relate to young people in their area. Since being formed approximately 12 months ago, local boards have established effective membership and have developed action plans to identify and respond to the needs of young people in their area, although it is as yet too early for them to demonstrate the impact of their work.

128. The Health and WellBeing Board (HWB) has gone through a period of significant review and development over the last 12 months, resulting in improvements in its ability to act as an effective strategic forum. Development sessions during early 2015 led to a revision of the terms of reference, membership and governance arrangements, in addition to the leader of the council taking over as chair of the Board. The chair of the Local Safeguarding Children Board has also joined the HWB, as has the Corporate Director, and these partnerships are proving effective in supporting change and improvement. Changes were in recognition of the challenges faced by the Board in eliciting full engagement by key partners to ensure sufficient impact and progress of the work required. At the time of the inspection, the Board was in the middle of a review of the provision of emotional health and well-being services in response to feedback from young people. Outcomes from the review, to be implemented in April 2016, will include changes to commissioning arrangements for these services based on an improved understanding of need.

129. The local authority has knowledge of local communities via the information gathered and collated in the online Joint Strategic Needs Analysis (JSNA)and a good range of general data informs commissioning of services well. Where this information is not sufficiently detailed, additional work, including consultation with young people, is undertaken. Priorities for current commissioning, such as placements for looked after children and care leavers, emotional health and well-being and the provision of advocacy, reflect key issues identified by young people.

130. The lead member for children's services is experienced and committed and demonstrated a sound understanding of progress against current priorities, including radicalisation and child sexual exploitation. He exercises his challenge function robustly within the limitations of the accuracy of the information he receives. He holds the DCS, Local Safeguarding Children Board chair, Corporate Director and Chief Executive to account through regular one-to-one meetings and group performance meetings, which consider data and findings of case audit activity of front-line practice.

131. Scrutiny by the wider political leadership of children's social work that does not fall under the remit of the health or education scrutiny committees, takes place as part of the much broader agenda of the bi-monthly scrutiny committee. There are no arrangements for regular reporting of children's social care issues to the committee and, as a result of the wide-ranging remit, an item relating to children's social work is discussed only four times per year.

132. Political leaders demonstrate commitment to their role as corporate parents and display knowledge and understanding of the needs of young people looked after and the issues that are significant to them. Representation of young people is a strength in the Corporate Parenting Board and minutes clearly demonstrated their participation and engagement. The Board is limited in its ability to scrutinise key areas of performance, such as the completion of personal education plans, by a lack of robust performance information. The Board has challenged the local authority in respect of some issues, but these are often verbal discussions and a lack of robust recording does not support further monitoring of any progress made.

133. Practice standards published in June 2015 are not widely understood and have not yet resulted in consistent quality of practice. As a result, the quality of social work practice experienced by children is too variable and widespread weaknesses exist in some areas. Many staff feel well supported by their line managers through informal conversations and report easy access to senior managers and the head of service. Management oversight of front-line practice through case discussion and formal supervision is often present on children's files but is not of sufficient quality to be effective in ensuring the meeting of these standards or in demonstrating any continuous improvement.

134. The local authority has a detailed supervision policy that sets out clearly the purpose and content of effective supervision, including the requirement for reflective practice. Inspectors' review of supervision found huge variations in frequency from regular recorded monthly meetings for some staff to support workers holding caseloads of child in need work who had not had formal supervision for up to four months. Where supervision had taken place, the quality of records seen was not consistently good. Despite some audit work taking place and senior managers being aware that supervision was inconsistent, there has not been any systematic evaluation of supervision across the county nor of its impact on practice.

135. The local authority has not analysed the impact of the current workforce profile on the quality of services provided for children and young people. The local authority recognises staff retention as an issue, exacerbated by the restructure in April 2015 when a number of vacancies were created due to internal promotion. As a result, the local authority has recruited large numbers of newly qualified social workers (NQSW). At the time of the inspection, over 45% of social workers in locality teams had been qualified for less than two years. This group of staff sometimes undertakes complex child protection work and often holds higher caseloads than the local authority considers

appropriate. The local authority has failed in some cases to meet national standards in the supervision of social workers during their assessed and supported year in employment (ASYE). Senior managers, while acknowledging these issues, have not yet taken authoritative action to address them. A recently developed recruitment and retention strategy includes staff feedback regarding work-life balance but does not evaluate or address other concerns.

136. An appropriate range of training is available to staff in children's social work and the training plan for the year is easily accessible to all staff. Social workers in Lancashire receive some induction support during their ASYE and have access to appropriate training. However, the local authority has no written policy in relation to the support offered to newly qualified social workers who are part of the ASYE programme in children's social care. As a result, new workers are not clear about the support they can expect, and there is variation in support across locality areas. The local authority does not evaluate attendance or impact of training attended to inform its effectiveness.

# The Local Safeguarding Children Board (LSCB)

## The Local Safeguarding Children Board is good

## Executive summary

Lancashire Safeguarding Children Board (LSCB) is meeting its statutory responsibilities and has formed clear protocols and shared priorities across all strategic partnership. Working relationships and cooperation across the partnership are strong with appropriate focus on children and families.

The Board is influential and has initiated a programme of improvements in key areas of safeguarding and child protection, for example early help, children missing from home and care, and children at risk of sexual exploitation.

The Board engages in a variety of meaningful ways with children and young people to enable their views and opinions to influence and shape priorities and improvements. It prioritises the needs of looked after children and is working jointly with the Corporate Parenting Board to improve the quality of placements across the area. It has challenged partners and can demonstrate its impact in a number of important areas for children and families

The multi-agency training programme is diverse, well evaluated and is starting to be measured for its impact on frontline practice.

The Board facilitates a comprehensive multi-agency auditing programme to test the quality of practice and services to inform improvements. Audits have examined thresholds for early help but have not yet focused on testing out that thresholds have been appropriately applied at every stage in the child's journey.

The Board has identified female genital mutilation as a priority in the business plan. A lack of information about prevalence makes it difficult for the Board to effectively hold agencies to account for the safeguarding of children and young women who are at risk of or have experienced female genital mutilation.

The Board's annual report does not include findings from its analysis of changing patterns and trends in child protection categories. This is a missed opportunity to share what has been learnt across the wider partnership and with the public.

## Recommendations

137. The LSCB should analyse and report on the prevalence of female genital mutilation to hold agencies to account for their practice in protecting girls at risk or in need of services (paragraph 160).

138. Ensure the LSCB annual report fully reflects the analysis and conclusions the Board has reached, particularly any changing trends in the categories of child protection plans, and what this means for understanding the effectiveness of performance and the quality of frontline practice (paragraph 163).

139. The LSCB should further support and challenge the local authority in making the necessary improvements to its help and protection provision and its services to care leavers (paragraphs 139, 146 149,150,158,159).

140. The LSCB should take action extend its understanding of the application of thresholds beyond early help to every stage of the child's journey (paragraph 159).

## Inspection findings – the Local Safeguarding Children Board

141. Lancashire Safeguarding Children Board (LSCB) is meeting its statutory responsibilities and has agreed clear protocols with all key strategic boards with responsibilities for children and families. These set out cross-board memberships, information-sharing and reporting arrangements on the agreed shared priorities to safeguard children.

142. The LSCB is chaired by an independent chair that is well respected by partner agencies in Lancashire, and is well- supported by effective business arrangements. The interim business manager ensures the business of the Board runs effectively. Partners at all levels consistently report strong leadership from the Board, with positive but appropriately challenging working relationships. The focus is to improve the quality of services and the experience for children and families.

143. Board members are of appropriate levels of seniority in their organisations to influence change, for example they agreed compulsory child sexual exploitation training for all those working with or in direct contact with children and families across the workforce.

144. The independent chair has been influential during her term from March 2014, and has led the Board in a number of areas that benefit children and families. The Board has given strong challenge to shortfalls in responses to children's health needs. It has influenced actions to reform mental health services for children in response to suicide rates. It has robustly challenged the slow pace of these reforms increasing progress. The Board has challenged health partners about the poor timeliness of health assessments for looked after children and ensured key posts such as health professionals and qualified

social workers are located within the MASH. Presentation of the Board's diagnostic of child sexual exploitation to the police and crime commissioner resulted in the offer of interim funding to source therapeutic support for children who are victims of sexual exploitation. The chair also ensured that the Board considered the impact of organisational restructure of the local authority on safeguarding and other front-line practice.The Board, supported by the chair's leadership, has robustly challenged the shortfall in the number of children with personal education plans and monitored the number of cases held by front-line practitioners. All challenges made have been based on the best information available, robust, frank, open and persistent.

145. The recent annual report for April 2014–15 reports some slippage in attendance during the restructuring of services, and there has been challenge from the chair to improve this to the very few agencies involved. Attendance this year has improved and is closely monitored to ensure it is sustained. The appointment of lay members is underway, resulting in a period with no independent lay perspective on the Board. The financial arrangements are agreed and sufficient to progress business priorities.

146. The LSCB's priorities are in line with local needs and progressed through well-established sub groups with clear terms of reference, action plans and reporting arrangements. Partners share responsibilities for lead roles although consistent representation from schools and colleges is a shortfall. The e-safety sub-group, in conjunction with young people, has introduced some innovative practices to combat the challenges of online risks.

147. The Board has led on a range of key safeguarding areas as a result of identifying responses for children that are not good enough. These are early help, child sexual exploitation and missing children. The Board has undertaken detailed reviews of arrangements and formed action plans that challenge all responsible agencies to improve. Reviewing progress sits with sub-groups with regular reporting arrangements. A review of the strategic and operational arrangements for the investigation and prevention of child sexual exploitation across Lancashire has been undertaken in conjunction with neighbouring Boards. This is in response to learning from influential reports on practice such as the Jay report on safeguarding practices in Rotherham. The Board has received written responses from all the relevant agencies on the progress they are making against the action plan. The chair of the Board also chairs the pan-Lancashire child sexual exploitation sub-group to further facilitate the improvements and consistency across the three local authorities.

148. In 2014 the Board challenged partners to improve the early help support that children and families receive as a result of findings from a Board-led comprehensive thematic inspection that effectively identified the scope of necessary reform. The oversight and monitoring of early help and the progress with reform sits with the Children's Trust boards with oversight by the LSCB. The local authority lead for early help reports progress and shares performance information through the monthly quality assurance sub-group.

The Board had challenged the delay in implementing the improved common assessment framework in 2013. According to the Board's figures, this is now having an impact, with the number of children and families receiving assessments and support for early help increasing by 50%. The multi-agency early help scorecard developed as a result of findings from the inspection is in the early stages of development and the Board will receive the first quarterly report by March 2016.

149. The Board focuses on children looked after and there are a number of areas of activity. It has completed an audit to understand better the experiences and equity for children placed by other local authorities in Lancashire. This was completed at the time of the inspection and its findings were due to be reported at the next Board meeting. Of particular concern is the quality of arrangements for other local authorities to visit their children after episodes of going missing. As a result of the audit, the Board is using its influence to ensure providers include details of how return interviews will be conducted as part of placement agreements for young people placed in Lancashire out of their home area. It is the intention to repeat this audit for Lancashire children placed in other areas.

150. The Board is actively engaging with the private sector and has facilitated a conference for independent providers to discuss safeguarding, including their responsibilities for children looked after under the local missing from care and child sexual exploitation procedures. The Board has developed, in partnership with the Corporate Parenting Board, arrangements to engage and challenge providers to improve the quality of their care. This is in the early stages, with one pilot panel undertaken. Children looked after are part of the panel and can form and ask questions of the independent sector representatives based on their own experiences.

151. The Board, through the learning and development sub-group, facilitates a varied programme of training and e-learning in line with priorities and local needs. There is a diverse pool of trainers from different disciplines, demonstrating partners' commitment to ensuring good quality training that is specific to Lancashire. The Board routinely evaluates training for its effectiveness, including external scrutiny. Responsible managers are asked to evaluate the impact of training on staff after three months. There are some positive examples of impact, such as a practitioner recognising disguised parental compliance and changing the approach to the case, and another reporting more confidence in working with drug-using parents.

152. The Board values the contributions of young people and is creative in engaging with young people in as many areas as possible. Young people are involved in multi-agency mock inspections and report on the quality of children's homes. Young advisors facilitate e-safety training in primary schools, which has led to very positive feedback from the children and young people and they are involved in selecting and recruiting social work staff. Other examples of how young people have influenced developments include

supporting and facilitating sessions at conferences for professionals; children looked after presented the Corporate Parenting Board annual report to the LSCB; and young people contributed to training and developing guidance to improve responses to child sexual exploitation and e-safety initiatives. The Board has formed partnership arrangements with two neighbouring Local Safeguarding Children Boards to develop and maintain consistent policies and procedures. Good arrangements ensure timely reviews and updates to procedures in response to national and local changes and to incorporate learning from a wide range of activities. This includes local and national serious case reviews (SCRs) and recommendations from the Child Death Review Panel (CDOP). Action plans clearly track the progress of updates and these are completed promptly.

153. There are effective arrangements for ensuring consideration of lessons to be learned from the deaths of children (CDOP) and SCRs, which are shared with two neighbouring authorities.

154. The LSCB, through the SCR sub-group, makes timely recommendations to initiate serious case reviews. The rationale for recommendations is clearly recorded and in line with the criteria. Opportunities to learn from cases that do not progress to formal review are initiated through management reviews. All activity is focused on facilitating learning and making a difference to the experiences of children. The Board circulates regular learning briefings across the partnership, though a small number of the social workers spoken to by inspectors were not able to make a link between the learning and their own practice.

155. The CDOP sub-group has effective rapid response protocols and is able to draw on specialist expertise to inform its recommendations. Themes and trends, including lessons from other areas, are scrutinised to consider how to reduce deaths. For example, CDOP undertook a review to determine themes from an increase in suicides for young people. This led to a review of health pathways through the Health and Wellbeing Board. There are close links with the SCR sub-group, with the chair a member of CDOP. There are examples of both groups communicating and testing each other's recommendations.

156. The Board oversees an extensive auditing programme, which has been increased to both mitigate the shortfalls in performance data and better understand themes identified in SCRs, thematic inspections or multi-agency 'mock' inspections of districts. The audits identify areas where practice is not good enough, for example the quality and analysis in assessments and lack of supervision. The Board has persistently challenged the areas where there are shortfalls in data and is routinely robustly monitoring the progress to improve intelligence and consistently understand prevalence and patterns at a strategic level. Front-line practitioners are not sufficiently involved in all aspects of audit activity undertaken. The Board is aware of this and is considering how it could increase their involvement in multi-agency mock inspections.

157. The Board has published a clear threshold guidance known as the Continuum of Need and tests out the application of thresholds through all auditing and mock inspection activity. The findings of a sample of audits undertaken during the business year 2014-15 reported that in the majority of cases thresholds were well understood. The more recent child sexual exploitation diagnostic has identified some inconsistency across districts with applying thresholds for children experiencing or at risk of child sexual exploitation. The Board has challenged all services through the robust child sexual exploitation action plan. Some immediate actions were taken to secure key posts in teams and ensure risk assessments were completed by qualified workers. There has as yet been less focus on testing thresholds across the child's journey, for example at the point of becoming looked after or when a permanence plan is agreed.

158. The Board identifies female genital mutilation as a priority in the business plan. The prevalence of female genital mutilation is not well understood across all agencies, with very little intelligence known or shared. The Board has facilitated a female genital mutilation conference, facilitated training and produced a briefing for all agencies. A strategic group chaired by the police representative is responsible for progress with the action plan.

159. The LSCB publishes a timely report on progress against the key priorities. A lack of quality performance data has hampered the Board's oversight, particularly for early help, child sexual exploitation and return home interviews. The Board has continually challenged the position and identified areas to improve over the last year in all the key areas within its responsibilities.

160. A task and finish group is progressing actions to improve data quality and the ability to share the multi-agency data and intelligence for missing children. This is to support the reliable data from the police. The Board requests specific reports from each organisation to mitigate poor quality data, which results in agencies presenting more accurate information to the Board, but this is not yet sufficient. The shortfalls have been identified and improvements are underway, but it is too early for accurate and comparable analysis to be available for the Board in respect of these areas.

161. The Board has analysed the reasons for changing patterns and trends in child protection categories, for example the number of plans for emotional harm is now higher than plans for neglect. The annual report does not reflect this analysis, which is a missed opportunity to share the Board's understanding of trends and changing needs across the partnership and with the public.

## 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 12 of Her Majesty's Inspectors (HMI) from Ofsted.

**The inspection team**

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