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Dear Ms Moore,

Focused visit to Leicestershire local authority children's services

This letter summarises the findings of a focused visit to Leicestershire local authority children's services on 10 and 11 October 2018. The inspectors were Rachel Griffiths, Her Majesty's Inspector, and Dawn Godfrey, Her Majesty's Inspector.

Inspectors looked at the local authority's arrangements for children who need help and protection. Specifically, inspectors looked at the 'front door' arrangements for the service that considers contacts and referrals, including decision-making in the first response team. They also considered the effectiveness of strategy discussions and child protection enquiries, and the quality of assessments completed in the first response team.

Inspectors considered a range of evidence, including case discussions with social workers and team managers. They also looked at local authority performance management and quality assurance information and children's case records.

Overview

Leicestershire children's services were last inspected by Ofsted in 2016, when the overall effectiveness of the service was judged to require improvement to be good. Since then, with strong political support, a now permanent leadership team has driven steady and realistic improvements in the first response service. Their push to increase capacity, reduce caseloads and create a learning environment has been successful in stabilising the workforce, resulting in children and families receiving improved services.

Senior leaders know their service well. They gain an understanding of social work practice from a range of quality assurance activities, which include thematic audits, social worker self-assessments, feedback from families, performance data and practice observations. Learning from these activities is shared in what social workers describe as a 'high support, high challenge culture'. This results in them feeling well supported and safe in their practice. Senior leaders know what the strengths of the service are, but they also recognise that there is much more to do to achieve the goals in their 'road to excellence' improvement plan.

What needs to improve in this area of social work practice:

- Partners' consideration of thresholds, the quality of their referrals and their understanding of consent.

- The timeliness of social workers visiting and talking to children who have been initially assessed as not at immediate risk of harm.

- The speed and quality of management decision-making when section 47 enquiries are being considered needs to be more consistent.

- The clarity of recording actions, with timescales, as a result of strategy discussions.

- Consistency in the quality of assessments, including them being completed within a child's timescale.

Findings

- Senior leaders gather and use performance data well to aid their understanding of their services and identify key areas for action. A wide range of quality assurance tools are used which provide senior managers with a rich source of information, enabling them to evaluate improvement and plan effectively. The case audits seen by inspectors were child focused and accurately identified areas of strength and areas for improvement. Staff spoken to during the inspection valued the feedback from audits.

- Leicestershire's first response service now has a stable workforce. Staff feel supported and valued. Good practice is celebrated and shared, and morale is high. Staff value the learning culture that has been created and praise the role of the local authority's practice excellence team, which is assisting them to raise practice standards. Consequently, children and families are getting a better, more reliable service.

- Team managers in the first response team promptly analyse and risk assess all contacts. Risks that are identified as significant are immediately escalated to ensure that actions are taken to safeguard children.

- In less urgent situations, and when contact information requires clarification, team managers request further work to be undertaken before a decision is made regarding the outcome of the contact. While this is appropriate in certain circumstances, inspectors saw examples where it delayed decision-making for up to 10 days. For some children, this has resulted in delays in them being seen and in their needs being assessed. Once decisions are made, they include a clear rationale.

- The response to domestic abuse notifications and contacts has been strengthened by a pilot involving the co-location of a social work team with the police. This has resulted in tangible improvements to the speed and quality of response to domestic abuse concerns, and in turn better safeguards children. This pilot is under review and senior leaders have recognised that this valuable service could be enhanced further by integrating more closely with Leicestershire's early help offer.

- The quality of contacts and referrals from partner agencies is variable and demonstrates a lack of consistent understanding of thresholds. In poorer referrals, information is vague, and in some instances, children are being referred when their needs could be met through universal services. Additionally, while first response workers understand the importance of seeking consent from families, this understanding is less consistent across partners. Unnecessary work is being created, meaning valuable time is being lost dealing with inappropriate referrals and gaining parental consent.

- Too many children are re-referred to children's services for the same or similar issues as before, meaning that previous interventions have not resulted in sustained improvements in children's lives. Too often, social workers see children's referrals in isolation rather that piecing together histories and analysing outcomes from previous assessments or contacts in order to inform planning. Senior leaders are fully aware of this and a range of initiatives are underway to improve practice to help children and families sustain positive changes without recourse to repeated statutory intervention. It is too early to see the impact of this.

- In a small minority of referrals, where it was unclear from the information received whether the threshold for a strategy discussion and section 47 enquiry was met, inspectors saw delays in further information gathering and in these children being seen. This left these children in uncertain, unassessed situations for longer than necessary, and without services and the right support being provided.

- Once a decision is made that a strategy discussion is required, these take place promptly and with a good level of multi-agency engagement, information-sharing and appropriate professional debate and challenge about threshold decisions. The rationale for decisions is clearly recorded, but actions, with timescales, are less clear, thus creating the potential for drift and delay for children.

- Social workers visit and see children quickly when they are assessed as being at risk of imminent harm. However, there are sometimes delays in other children who need support being seen by social workers. Inspectors saw examples where delays were introduced throughout the process: between contact and referral, between referral to allocation and between allocation to visit. This resulted in a minority of children not being seen for up to 20 days after the point of contact. Senior leaders are aware that a lack of performance data in this area is hindering their understanding of the issue and they are seeking to develop performance information to aid their oversight.

- The quality of assessments is variable. Strengths identified in assessment work include multi-agency contributions, evidence of direct work with children and their views informing the assessment, and the inclusion of absent parents. In better assessments, a balanced assessment of risk was seen, resulting in proportionate responses and recommendations. This was lacking, however, in a minority of assessments.

- Most assessments are completed within statutory timescales, but this is not always proportionate to children's needs. Some assessments could have been completed more quickly, resulting in earlier service provision. Support services are not routinely provided during the assessment period. This means that children and families can wait too long to receive an appropriate service.

- On allocation, team managers provide social workers with clear direction regarding the actions required to complete each assessment. However, reviews of the progress of assessments are not consistently completed. Supervision, though mostly regular, is not always effectively steering case progression.

- The recently re-configured out of hours service is effective and provides children in Leicestershire with good support and protection outside office hours.

Ofsted will take the findings from this focused visit into account when planning your next inspection or visit.

Yours sincerely

Rachel Griffiths
Her Majesty's Inspector