Inspection of local authority arrangements for the protection of children

Peterborough City Council

Inspection dates: **28 January – 6 February 2013**
Lead inspector **Christopher Sands HMI**

Age group: All

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The inspection judgements and what they mean

1. All inspection judgements are made using the following four point scale.

Outstanding	a service that significantly exceeds minimum requirements
Good	a service that exceeds minimum requirements
Adequate	a service that meets minimum requirements
Inadequate	a service that does not meet minimum requirements

Overall effectiveness

2. The overall effectiveness of the arrangements to protect children in Peterborough City Council is judged to be **adequate**.

Areas for improvement

3. In order to improve the quality of help and protection given to children and young people in Peterborough City Council, the local authority and its partners should take the following action.

Immediately:

- ensure that children's social care reports to child protection conferences are made available to all parents and young people as appropriate in advance of the conference
- ensure that rationale for decision making by managers is clearly recorded on case files
- ensure that strategy discussions include all relevant parties so that all information relating to risk is identified and acted upon and that strategy meetings are held where appropriate
- ensure that Section 47 enquiries effectively consider information from all known professionals on which to make an informed decision.

Within three months:

- implement a further programme of awareness raising and practice training within the children's services to ensure all risks to children are understood, identified, comprehensively assessed and acted upon at an early stage

- ensure plans for children are child focused with measurable outcomes
- ensure that children's views and wishes are fully informing assessments and planning for children
- ensure that assessment processes actively engage fathers and male partners to ensure that children's representation at case conferences is improved, both in person and through the advocacy service
- ensure that children's representation at case conferences is improved, both in person and through the advocacy service
- ensure that the Peterborough Safeguarding Children Board has sufficient high quality information to enable them to monitor and challenge practice across all agencies.

Within six months:

- ensure that social workers have the opportunity to fully reflect on case work, enabling a considered overview of the child's assessed needs and an understanding of the child's experience
- improve the quality of chronologies to ensure that they provide an effective and informative overview of significant events
- ensure that specific therapeutic services are commissioned for children who have been involved in domestic abuse
- ensure that the Peterborough Safeguarding Children Board reviews the attendance of relevant agencies at child protection conferences along with the timeliness of reports being available
- ensure that the Peterborough Safeguarding Children Board develops a robust auditing programme that includes a focus on the experience of the child and the impact and outcomes of service provision and that this leads to identification of themes and plans for improvement which are robustly implemented and monitored
- implement the universal use of CAF across all early help services including children's centres
- implement a systematic quality assurance process to ensure effectiveness of early help services
- strengthen the complaints annual report process to ensure that complaints and compliments about children's services clearly inform and support improvements in the quality of practice

- conduct a review of the newly commissioned interpreting service to ensure that it is delivering improved service provision and is able to meet the diverse language needs of the local community.

About this inspection

4. This inspection was unannounced.

5. This inspection considered key aspects of a child's journey through the child protection system, focusing on the experiences of the child or young person, and the effectiveness of the help and protection that they are offered. Inspectors have scrutinised case files, observed practice and discussed the help and protection given to these children and young people with social workers, managers and other professionals including members of the Local Safeguarding Children Board. Wherever possible, they have talked to children, young people and their families. In addition the inspectors have analysed performance data, reports and management information that the local authority holds to inform its work with children and young people.

6. This inspection focused on the effectiveness of multi-agency arrangements for identifying children who are suffering, or likely to suffer, harm from abuse or neglect and for the provision of early help where it is needed. It also considered the effectiveness of the local authority and its partners in protecting these children if the risk remains or intensifies.

7. The inspection team consisted of five of Her Majesty's Inspectors (HMI).

8. This inspection was carried out under section 136 of the Education and Inspections Act 2006.

Service information

9. Peterborough City Council has approximately 46,237 children and young people under the age of 19 years. This is 25.2% of the total population. The proportion entitled to free school meals is above the national average. Children and young people of compulsory school age from minority ethnic groups account for 38% of the population, compared with 24.5% in the country as a whole. The largest minority ethnic groups are Pakistani and White-Other. The proportion of pupils with English as an additional language is above the national figure.

10. At the time of the inspection, 253 children and young people were subject to a child protection plan. Children's social care services were providing support to 1,531 children and young people.

11. Early help and support is provided through a range of services including 15 children's centres and an early years and child intervention team.

12. Within the children's services directorate, child protection work is undertaken by a contact and referral team, four family support teams, a children's integrated disability team and an out of hours service

commissioned from a neighbouring local authority. Child protection support services include an adolescent services team, a direct intervention service, a family group conference service, a 0-19 service and a range of commissioned services.

Overall effectiveness

13. Overall effectiveness is **adequate**. At the time of the inspection, no children were found to be inadequately protected or at risk of significant harm. Additionally, there were no unallocated child protection or children in need cases. Through robust arrangements in the redesigned contact and referral teams, decisions are made promptly and referrals are appropriately moved into assessments within required timescales. As a result, children are being effectively protected. Within the wider children's services and partnership, a more recent focus on child sexual exploitation has accelerated the learning for the council from which good working relationships with the police have been formed and intelligence is being used effectively to protect children and young people.

14. The council has been under a notice to improve since June 2010 following an inspection in March of that year. This was followed up by a re-inspection of safeguarding services in August 2011 where overall effectiveness was again found to be inadequate. Since the last inspection significant changes in senior leadership have taken place. The lessons from that inspection have been taken seriously resulting in a determined drive to address the identified deficits through rapid improvement. The support of politicians and partners has been a key element to the improvement programme. This current inspection can confirm positive progress is being made in all areas for development identified in the re-inspection of safeguarding. However, the council acknowledges that there remains much to do and is committed to ensure sustainability of the current achievements combined with a relentless drive and focus to continue the positive direction of travel.

15. Early help services are accessible across the community and are becoming increasingly well established with a wider range of services now available compared to the time of the previous inspection. Services have been commissioned to ensure better targeting to reach and meet the needs of the most vulnerable communities and families with improved outcomes being evidenced. The council has higher than average referrals and re-referrals which are the focus of a current audit to gain a full understanding of this dynamic. There is a correlation between the number of referrals and the need to enable community based services to feel more confident in addressing and managing additional need. However, the use of the common assessment framework (CAF) is increasing, especially within primary and secondary schools and the recent introduction of multi-agency support groups are beginning to have an impact through more accessible services and resources. The number of referrals and re-referrals is now showing signs of reducing.

16. Through a number of mechanisms, the views of children, young people and their families are being gathered and in most of the activities observed by inspectors and through feedback processes, service users are

reporting positively on the services they receive. Where they are able to draw a comparison, parents told inspectors that they had noticed an improvement in their accessibility and contact with social workers and the support they were now receiving. However, the council recognises this to be an area for further development and has in place two initiatives to engage and seek the views of children, young people and parents to inform service improvement and planning.

17. Leadership and governance arrangements at senior officer level are now strong with evidence of a real drive and energy to address the past failings and to achieve sustained improvements. Strengths and weaknesses are well understood with external validation and review used effectively to confirm progress and to identify further areas requiring attention. The independently chaired Improvement Board has been the primary vehicle for challenging progress and promoting improvements supported by regular reporting to the creating opportunities scrutiny committee. The engagement of elected members has become strong also through an increased confidence, oversight, challenge and sense of responsibility. Members on the scrutiny task and finish group visit staff in their offices and accompany them on visits in order to satisfy themselves that the service is improving. Performance monitoring is now well established and is being used increasingly effectively to address areas of concern.

18. Whilst the senior leadership is displaying a strong and very engaged approach with practice on the front line, the leadership team still requires a full complement of permanently appointed staff with the current head of safeguarding and communities being an interim appointment. The post of Chair of the Safeguarding Board is currently vacant, being covered by the deputy chair. Similarly, some middle manager posts are currently covered by agency staff. Care is being taken appropriately to appoint experienced staff with the necessary drive and determination to continue to improve services. The council recognises that there is much yet to do, especially in moving from their intense focus on quantitative monitoring to improving the quality of practice. Commendably, the council has indicated its continued commitment and intention to maintain the current Improvement Board with an independent chair to sustain and secure ongoing improvement.

The effectiveness of the help and protection provided to children, young people, families and carers

19. The effectiveness of the help and protection provided to children, young people, families and carers is **adequate**. Children and young people at risk of harm are effectively identified by both early help and children's social care services. No cases during the inspection identified children to be at risk. In the majority of cases, the needs of children and young people are responded to promptly by services appropriate to their level of

need. Recent improvements in the contact and referral team in particular have led to efficient and effective oversight which protects children. Children known to social care are visited regularly by social workers who understand them well. In most cases this results in the management and minimisation of risk which enables children to remain safely at home with their parents.

20. Multi-agency support groups (MASG) effectively support consistent management of risk and the transfer of cases from children's social care to other services. However, a few cases demonstrated inaccurate assessment of risk and signposting for support through team around the child (TAC) intervention where an immediate decision to instigate child protection processes would have been more appropriate.

21. The common assessment framework (CAF) team robustly assess the risks to children in each new CAF referral against the city's threshold document which ensures a consistent approach to case management. The majority of CAFs completed include issues of domestic abuse. Whilst plans provide services to help adults, there are too few services at tier two level (between universal and specialist service provision) providing easily accessible therapeutic help for children. The council acknowledges that this is an area for development

22. In cases of child sexual exploitation (CSE), strategic prioritisation and improved management oversight has, in the majority of cases, resulted in early identification of vulnerable young people and more rigorous risk management. A good example is the additional and specific layer of assessment identifying potential risk factors for young people who are reported missing. Even where the risk is assessed as at a low level, assessments are forwarded to the police and after three incidents of going missing a complex multi-agency strategy meeting is convened. However, this is a recent development and in some cases seen young people at potential risk of CSE had not benefited from a multi-agency strategy meeting to comprehensively assess all known risk factors.

23. Accelerated learning has recently increased the robustness and identification of young people potentially at risk of CSE. The Peterborough Safeguarding Children Board (PSCB) has begun to implement a good quality multi-agency action plan coordinating the roles of agencies in addressing issues related to CSE. Some actions such as identification of risk factors and referral pathways are already complete. However, some aspects of the plan, specifically disruption and prosecution activities, have yet to be implemented and it is too early to demonstrate effectiveness.

24. The pupil referral unit supports the development of good behaviour management and provides effective access to alternative provision for those primary and secondary age pupils excluded from mainstream provision. As a result, children are quickly and effectively reintegrated to

mainstream provision making good progress to catch up with the attainment of their peers.

25. Overall, children, young people and their families feel satisfied with the quality and nature of the help they receive and families' views on the effectiveness of help are built into CAF and TAC processes. In particular a group of vulnerable young women expressed high levels of satisfaction, feeling fully included and positively helped. Children's centres and the adolescent intervention service (AIS) systematically collect views of families and young people and high levels of satisfaction are reflected in their sustained positive outcomes. Parents spoken to during the inspection reported positively that social workers have time for them and they feel listened to.

26. The effective engagement of children and families is an explicit priority for senior managers and is well evidenced by the implementation of the strengthening families method of managing child protection case conferences, where the views of parents and children are fully included. Managers routinely receive and collate views of parents subject to child protection processes. Most who respond are clear about what needs to change for a child protection plan to be removed.

27. Generally, help and protection is sensitive to the individual needs of children and families with regard to their culture, language and disabilities. Targeted youth groups, provided to meet different gender needs and specific cultural needs such as a dance and drama groups for Roma Traveller young people, have good impact on the participants but there is too little provision and waiting lists are growing. In the children's integrated disabilities team most cases seen demonstrated a lack of child centred practice. In one case a sibling group subject to a child protection plan had not had their needs effectively assessed or monitored.

28. Particular challenges, acknowledged by the council, remain in the provision of a reliable and effective interpretation service. Senior managers have recently re-commissioned the service in an effort to raise standards and better meet the needs of the community, but it is too early to assess the impact of new arrangements.

29. An effective specialist team, the minority ethnic new arrivals team, includes staff who are bi-lingual in a range of languages including Slovakian, Lithuanian, a range of Roma dialects and Portuguese. The team is engaging positively with a high percentage of children who are not registered at schools in the city. Nearly all become successfully engaged in education and benefit from an improved sense of belonging and emotional well-being.

30. The early help offer is accessible across the community and includes both council and commissioned services. Services including children's centres are located in the areas of greatest need and are effectively reconfigured

to respond to changes in local needs. Although the prevention and early intervention strategy has been implemented recently, some children's centres do not use CAF as their common assessment tool, preferring to retain the use of their own individualised processes when undertaking work with partner agencies. Significantly, although this multi-agency work helps professionals to identify and manage risks to children, their parents are not specifically asked for their consent to information being shared nor is there a holistic assessment undertaken. Plans made under such individual arrangements are not subject to routine or robust review. The result is that this work, outside the realm of the common assessment processes, does not have overarching management oversight or effectively contribute to the gathering of comprehensive management information about local need.

31. High intensity family support delivering improved outcomes is provided by an independent organisation. Effective practical support programmes for vulnerable families are well established and evidence demonstrates clearly their contribution to reducing and minimising risks for children. The AIS and targeted youth services are well understood by partner agencies and good signposting enables effective access. The connecting families programme, whilst in its early stages of development, is supported by strong partnership arrangements and is already showing positive outcomes.

32. Schools are central to the provision of a wide base of early help services. The number of CAFs initiated by primary schools has risen by a third in the past two years and secondary schools maintain a steady pace of growth in this area of work. Schools welcome the access to resources through the MASGs and are able to secure intensive support at very short notice. These arrangements build on schools' existing good contacts with a wide range of services to help children manage their behaviour and reduce risks to expand the range of teams around children and their families. Evaluation of early help is underdeveloped despite a full evaluation of CAF and its impact being undertaken in 2012. Actions taken to address deficits, particularly in relation to training, have been put in place but as yet it is too early to see any improvement.

33. Good and effective multi-agency working is evident both in TAC plans and the recommendations made on a routine basis by the MASG. CAFs demonstrate this further and are completed by a wide range of professionals including schools, health visiting and housing agencies. Regular and helpful communication between practitioners from a range of locality based agencies positively supports on-going work.

34. The majority of children are referred appropriately to services that best meet their needs. The impact of plans to protect children or support those in need are generally effective and case files demonstrate risk being steadily reduced with the aim of safe transfer from statutory to other

services being achieved in the majority of cases. In September 2012, senior managers completed an effective audit of cases subject to child protection processes in the light of rising numbers. Their findings, confirmed by the majority of cases scrutinised and observed during this inspection, demonstrate clearly that only very few cases were able to be considered for signposting or transfer to prevention and early intervention services and that children are not unnecessarily subject to formal processes.

The quality of practice

35. The quality of practice is judged to be **adequate**. Inspectors saw some examples of good work by individual social workers and other staff. However, this is not yet sufficiently consistent across the service. Some examples of poor practice were evidenced in assessment and analysis which contributes to this inconsistency. Overall, the majority of cases seen by inspectors were satisfactory with effective risk assessments and decision making. During the inspection, no children were found to be inadequately protected or at risk of significant harm and there were no child protection or children in need cases which were unallocated.

36. The single point of contact is responsive and well resourced to meet the current volume of referrals. Decision making in this service is effective and timely, with good management oversight. Professionals report positively about the value of being able to consult with a social worker in the contact and referral team if they have a concern or issue before making a formal referral or to assist in deciding whether another option would be more appropriate for a family.

37. Representatives of schools, academies, children's centres and health services spoken to expressed confidence in making referrals to the contact centre. Observations of a MASG and review of contacts and referrals confirmed that universal services generally make appropriate and timely referrals of adequate quality to children's social care.

38. An audit of the application of thresholds in November 2012 concluded that in general terms thresholds were being appropriately applied and this inspection concurs with that finding. However, the rate of referrals remains high, suggesting that that there are some children's needs that could be met by other services. The council is aware of the high number of referrals, which includes re-referrals, and at the time of the inspection was in the process of undertaking an audit to understand this further. A new threshold document has recently been published to support agencies in deciding the most appropriate referral route. For lower levels of concern, universal services find discussions at the MASGs invaluable and highly responsive.

39. The out of hours service is providing an effective and efficient service. The service has access to the council's electronic case records and this

supports timely recording of interventions and contacts out of office hours. Information sharing arrangements are firmly in place for when a social worker needs to inform the service of any potential issues which may arise outside office hours.

40. Most strategy discussions are held promptly but are usually a telephone discussion between the police and social care only. In a small number of cases seen, the need for a strategy discussion following a disclosure by a child or contact from a professional was not recognised. In these cases statutory processes were not followed, resulting in the range of risks to the child not being fully assessed. Some cases were seen where it would have been more appropriate to convene a strategy meeting with all relevant professionals, in order to share the fullest information available on which to then agree a plan of action.

41. At the time of the inspection, the children's integrated disability service (CIDS) made decisions about child protection referrals and enquiries. However, as a direct result of two cases being referred to senior managers where due process had not been followed sufficiently, decisive action was taken to transfer the responsibility for all strategy discussions and subsequent enquiries to the referral team as an interim measure to ensure a robust and consistent approach.

42. Section 47 child protection enquiries are undertaken by suitably experienced and qualified social workers. The quality of these enquiries is variable. In most cases, an adequate and clear record of the enquiry is evident and in the more recent cases, the quality was much improved. In some cases, enquiries are only being made in relation to police and children's social care with few records of checks with health, probation, education or other known professionals.

43. Decision making in the referral and assessment teams is carried out at all times by qualified and experienced social workers and managers and decisions are recorded effectively in case notes and on assessments. In most cases the rationale for decisions is clear and follows the recommendations made by assessing social workers. However, in some cases seen, the rationale for managers' decisions is not recorded.

44. There is a good recognition that domestic abuse presents a risk to children in households where this is a feature. The police refer all incidents of domestic abuse where they have responded to an incident and children are present. These are currently risk assessed by the police with the council having plans to develop a multi-agency screening process. Schools are notified where there is considered to be a medium to high risk following a domestic abuse incident. Services are available to provide interventions and support to perpetrators and to adult victims of domestic abuse, and there is some support to children in schools through the personal, health, social and economic (PHSE) agenda. A recent needs

analysis recognises that specific therapeutic support for children who have experienced or witnessed domestic abuse needs to be enhanced. An action plan is in place which includes the development of more services for children.

45. Pre-birth assessments seen by inspectors are of satisfactory quality, with some examples of effective work between health and social care agencies, for example agreed discharge planning meetings from hospital, and good communication between midwives and social workers. Assessments seen resulted in effective actions to protect children.

46. Initial and core assessments are timely, with some being very thorough and demonstrating a good analysis of risk. Overall they are of satisfactory quality, but too many seen do not sufficiently identify family or environmental factors on the impact on the child's well-being. In some cases the recognition of risks is not clear. This results in plans which are inappropriately focused on the achievement of activities and practical arrangements with little emphasis on measurable improved outcomes for the child. Where plans are good, they identify a realistic timescale for actions to be achieved which relate to improving outcomes for children. In the small number of good assessments seen, these included a clear focus on the child and a succinct but full analysis of the impact on the child of the strengths and risks identified. However the quality of assessments is too variable, with a minority of cases seen failing to identify all risks.

47. The electronic case recording system automatically produces a chronology of events, but these are not always useful as they do not necessarily identify the most significant key issues. In some but not all cases seen social workers have identified key significant issues as part of core assessments or reports to child protection case conferences, and this helps to ensure the assessment is thorough and analyses all the background history in identifying the child's needs.

48. The involvement of children and young people in assessments, service delivery and planning is too inconsistent, ranging from inadequate to good. Where good engagement with children and young people was seen, their views and experiences were reflected well in assessments and in plans for their care. In most cases reviewed children were seen and where appropriate seen alone by social workers who were often able to demonstrate competent skills in engaging children and young people.

49. Many social workers were able to articulate how well they knew children as they described their casework to inspectors. Parents spoken to by inspectors stated that recent practice was more child focused and social workers spent time getting to know their children. This made parents feel more confident about the help they received. In some cases, particularly in the CIDS, effective relationships with children were not strongly evident, and assessments and plans were sometimes more focused on the

support needs of parents than the developmental needs of children. Examples of feedback from children about the services they receive are limited. Where they are available, for example through the youth service, they are very positive.

50. In CAF cases reviewed, plans are not sufficiently focused on the views and experiences of children and young people. Whilst there are some examples of children's views being elicited well for TAC meetings, those reviews sampled demonstrate that this work is not well developed. In most cases, children's views are represented but the record does not always give a real picture of how a child feels or what their life is like.

51. Case recording is in most instances coherent and timely, with social workers commenting positively on the effectiveness of the electronic case recording system. However, outcomes for children are not always clearly identified and in a minority of cases there was a lack of coherence between assessments, case recording and plans, making it difficult to follow the progress of work and to fully understand the child's experience.

52. Cases sampled by inspectors demonstrated variable management oversight on the child's case record, ranging from adequate to excellent. In many examples this was as a signature on the assessment, or a specific case direction and some had both. In the CIDS team this was less evident, resulting in a lack of direction and child focused responses in a small number of cases.

53. Social workers described being supported in their work through the availability of managers who provide formal and informal supervision.. The quality of formal supervision records varies from regular monthly case discussions with reflection and challenge in a minority of cases, to some which had long gaps between meetings and little by way of case direction or personal and professional development goals for staff. Some casework was seen which was reactive to meet the child's identified needs rather than being informed by a full understanding of the case through reflection. However the majority of supervision records seen were satisfactory and inspection findings echo the council's own audit outcomes which has made sound recommendations to improve supervision practice.

54. Social work reports for case conferences are not always routinely shared with the family prior to the meeting, although some good practice in this respect was seen. Reports do not always reflect the comments and views of families. Reports from other agencies are often, but not always, shared in advance, but police reports are not shared before conference. This can result in families having to absorb a large amount of information at the time of the meeting, which can be stressful and emotive, particularly if they do not agree with the information presented, and have not been given time to consider their response.

55. Child protection conferences are convened in a timely manner and regularly reviewed within prescribed timescales. Conference chairs are skilled and well qualified for their role. Chairs check routinely that standard practice expectations are met, providing a useful quality assurance role. For example, confirmation is sought from parents that they are made aware of their right to complain. The regularity of visiting and core groups being held are checked also to ensure they meet statutory regulations. However, in case sampling, there were incidents of drift in the timeliness of some core groups. There were also examples of core group minutes not being recorded in a timely way, making it difficult for managers or child protection chairs to check the progress of plans. Concerns about issues in practice are addressed by conference chairs through a system of 'practice alerts'. Examples reviewed demonstrated that this was a useful process in identifying poor practice or decision making, resulting in appropriate actions being taken to help and protect children.

56. The use of the strengthening families approach is very effective in engaging attendees in case conferences and focusing on the key issues. Inspectors observed this to be a constructive approach which enabled families to clearly see the risks and strengths and to understand why professionals may have concerns. Child protection conferences observed by inspectors were effectively chaired, although some social workers commented that case conferences can be too lengthy.

57. Case conferences are generally well attended by police, education and early years' health professionals. General practitioners do not routinely attend or send reports to meetings. This represents a possible risk that there is a missing link in the information sharing. Minutes of conferences are sent routinely to all invited agencies.

58. A review of case conference venues has resulted in improved accommodation for meetings in the city centre which is fit for purpose, although not always available. There are still some venues used that are not suitable in ensuring privacy for families and enabling the meeting to progress comfortably and without interruptions.

59. The advocacy service commissioned from a voluntary agency to support the attendance of children at conference is working well. There is a policy of inviting children to conferences where appropriate when they are aged 12 or over, but their participation is currently low. The council recognises that more work needs to be done to ensure children and young people are sufficiently prepared and supported to attend.

Leadership and governance

60. Leadership and governance are **adequate**. The council has taken the learning from the past inspection seriously and has worked hard to prioritise child protection and early help. The council has a thorough

understanding of its strengths and weaknesses and how these have impacted on services. This is demonstrated by significant investment from the council that has strengthened service provision. Priority has been given to the appointment of experienced senior leaders to address identified deficits and drive forward service and practice improvements.

61. Since the re-inspection of safeguarding in August 2011, the social work establishment has been increased from 56 to 81 social workers (excluding fostering and adoption services). The reliance on agency staff has been reducing through a successful recruitment campaign resulting in agency staff accounting for 13% of staff at the time of the inspection, a significant reduction from 32% in February 2012. Caseloads have reduced considerably and the majority of social workers report these to be manageable. This additional capacity has ensured that backlogs of initial and core assessments have been cleared and at the time of this inspection there was no unallocated work.

62. The detailed and wide ranging improvement plan, overseen by an independently chaired Improvement Board, has been the primary vehicle for the council's recovery phase, supported by a comprehensive performance framework. The senior leadership team and partners work to a single delivery plan and there is clear evidence of the strategic vision being conveyed with clarity to the workforce with significant activity taking place to address previous identified deficits.

63. 'Front door' processes have been re-designed within the contact centre and between the contact centre and the referral and assessment team. This has led to the consistent application of agreed multi-agency thresholds supported by an emerging prevention and early intervention strategy based on an up to date local needs analysis. Families are diverted appropriately into early intervention services including CAF and the more recently established AIS. The effective work of the contact team provides firm foundations for the recently agreed development of a locally based multi-agency referral unit (MARU) with Cambridgeshire constabulary.

64. Effective use has been made of external validation to maintain an active and current understanding of their strengths and areas for development. The council requested an Eastern Region Peer Safeguarding Health Check during the latter part of October 2012. The report, informed by a self-assessment described by the peer review team as 'robust, analytical and offering an appropriate critique of the authority's position and developments' identified many of the areas of effectiveness found during this current inspection. The peer review team also referred to a relentless drive for improvement led by senior managers and the increasing availability of early help services. The review confirmed the efficiency of work at the front door and highlighted the further priorities of the council to move the workforce from compliance to engagement and to secure permanent and effective middle manager posts. The findings of the review

have been used effectively to inform the prioritisation of further incremental change. The current inspection concurs with these findings.

65. There has been positive progress against all the areas for development since the last inspection, most notably in the management and capacity to respond effectively to contacts and referrals. The threshold document has been revised and agreed by the PSCB. This has been critical to establishing a more consistent approach to contacts, referrals and decision making in the referral and assessment service. A new electronic recording system is now firmly in place and is an efficient tool for both case recording and in generating reliable performance management information. The council is currently in the process of installing a business objects performance tool. This is designed to enable managers to contemporaneously manage and have oversight of their team's performance thus engendering management responsibility for performance at the most appropriate level.

66. Leaders and senior managers recognise that addressing weaknesses identified in children's services require rapid improvement, concerted will and the combined efforts of partners. This has led to the development of the Prevention and Early Intervention strategy informed by the views of partners aligned to capacity. The plan was very recently agreed and 'signed off' in January 2013. Early intervention strategies are clearly linked to an adequate needs analysis that utilised wide ranging indicators to identify current areas of need. Whilst improvements have been made to prevention and early intervention services, the strategy is relatively new and is yet to be fully embedded.

67. The connecting families programme is an innovative and sustainable approach to addressing the government's 'troubled families' initiative. Overseen by a wide range of partners using existing staff known as 'connectors' based in a range of services, the programme is working with an increasing number of families. While recently deployed, the programme is already delivering improved outcomes. Further work is yet to be done to routinely assess the financial efficacy of the programme in terms of savings delivered through this approach.

68. Knowledge of the increasing range of services available within the council's area and how to access these is supported and promoted by an electronic interactive services directory and a toolkit of local services. These exceptionally well prepared and comprehensive tools provide clear information, are updated on a regular basis and made available to a wide range of services and agencies.

69. The council recognised that the Children's Trust Board (CTB) had become too large to be wholly effective and its role and remit too wide to address priorities. Building upon established and valued partnership working, partners have recently agreed to replace the CTB with a Children's Joint

Commissioning Board (CJCB). The new Board has a tighter membership designed to promote greater accountability and clarity of purpose. The Board is accountable through the director of children's services and the lead members who report on the effectiveness and impact of work to the Health and Wellbeing Board (HWB). Terms of reference for the CJCB are agreed with clearly defined strategic priorities articulated well within the improvement plan. The improvement plan is in the process of being incorporated into a single delivery plan for children giving the highest priority to the safeguarding and protection of children and young people and replaces the children and young people's plan.

70. The strategic governance arrangements between the CJCB, the PSCB and the HWB are yet to be fully established to ensure the strategic priorities for children and young people are firmly embedded and understood with rigorous challenge. This contributes to a current diminished lack of effectiveness of the PSCB to hold these Boards to account.

71. Commissioning has been effectively focused to support the improvement plan and improve service resources from a low base where there were few services to support the front line and no clear pathways to access resources. Children's centres have been commissioned to deliver targeted services and panels have been established including the MASGs and the Peterborough access to services panel (PASP) which consists of education and social care professionals. Inspectors saw evidence that the panel approved the provision of resources promptly to support vulnerable families as well as providing an effective forum for managerial oversight of planning and interventions. Intensive family support services have been commissioned within the city and have been seen to be highly effective, delivering some positive outcomes. Services to families with complex needs and where long term neglect has been identified as a cause for concern are beginning to be delivered by a voluntary agency which is also introducing the use of the video interactive guidance tool to support parents' learning about their behaviours.

72. Domestic abuse is identified appropriately as a key priority by the Safer Peterborough Partnership. The domestic abuse strategy provides details of the range of provision for victims and perpetrators. The strategy is adequate and identifies current data and activity levels but is more crime focused than child focused. The need for more services for children who live in an environment of domestic abuse is recognised. The recently produced action plan includes a proposal to map services available to meet the needs of children. Activity identified within the plan is insufficiently outcome focused and does not set out specific measurable targets to meet children's needs.

73. A very recent document sets out the view and intent of local partners in relation to CSE under the auspices of the PSCB. The action plan is good and red, amber, green (RAG) rated to illustrate progress made. Some

actions to deliver an ambitious strategy are already complete. Priority has been given to identification of risk factors, referral pathways and staff training. A referral form has been developed between Peterborough and Cambridgeshire safeguarding children boards which uses the Barnardo's definitions of CSE to refer and risk assess those at possible risk. However, the strategy is too early in its implementation to demonstrate impact and effectiveness.

74. Accountabilities and responsibilities between the director of children's services, the chief executive and lead members for children's services are clear and have been strengthened as a direct result of learning from the past inspection. Increased and active oversight by elected members is firmly in place which has developed their understanding of strengths and weaknesses and has given them the confidence to challenge senior officers. The use of the members' task and finish group to visit front line services and to accompany social workers on visits is a good mechanism now in place for members to assure themselves that services are improving and to hear directly the views of staff and service users.

75. The Director of Children's Services and other senior managers provide strong and visible leadership, involving themselves appropriately in observing front line work and auditing practice. A social work forum was established last summer to include a representative from each of the children's services teams. During the period of extensive change, very effective use of the forum has enabled staff to have a voice, feel empowered and confident to raise issues with managers at all levels as well as elected members. Staff reported examples where the forum has had a positive impact and contributed to service improvements. During continuing changes within the service, the forum has helped significantly to manage anxieties and for managers to be made aware of concerns. Staff report they have confidence in their senior managers and that they will be able to sustain the current positive changes.

76. The PSCB meets its statutory responsibilities and has successfully appointed two lay members to assist it in its work. Interim arrangements are in place to cover the current vacancy of an independent chair. The council and partners are exercising due diligence in ensuring that the new appointment will be an effective lead with the necessary drive and challenge to enable the board to be an effective agent of change and improvement. The most recent annual report is comprehensive providing an overview of duties undertaken and some analysis of the effectiveness of this work. The role and structure of the Board has been informed by external review and there has been a recent streamlining of sub groups to reflect priority work. A strengthened quality assurance framework is being developed and there is on-going work to compile an agreed data set for performance management purposes. The effectiveness of these changes and the scrutiny function of the board are not yet fully embedded. Multi-agency case auditing, although it occurs, is not systematic and is

underdeveloped, failing to consistently review whether practice has changed as a result of audit activity..

77. The Board is aware that that much further work is required to identify and take into account feedback from children, young people and their families. A range of activity demonstrates that lessons learned from serious case reviews are disseminated to staff although with limited success. An example of this is in social work practice which continues to demonstrate insufficient consideration of fathers and male partners who remain largely invisible in child protection and child in need processes. Multi-agency training is well received and increasingly embraces e-learning opportunities. The Board is aware it has more to do to clarify training expectations, scope provision and measure impact and cost effectiveness longitudinally. Examples of joint work with Cambridgeshire Safeguarding Children Board have been seen to be effective such as the establishment of a joint child death overview panel.

78. Performance management and quality assurance arrangements for children's social care are increasingly well established underpinned by a well formed quality assurance strategy. The performance framework is clear and comprehensive, recognising the balance of quantitative and qualitative practice, locating accountabilities at every level from practitioner to director. High level performance management information is used well for monitoring compliance and has formed the basis of recent improvements in the overall quality of practice. The council acknowledges that the current quality assurance activity is predicated by necessity to issues of process, rather than the quality of practice and outcomes which is to be a key feature for the next phase of improvement activity. However, regular case and themed audits are undertaken to support improvements in practice. Most key indicators reflect a positive trend including the timeliness of assessments.

79. Child protection conference chairs are seen by the council as pivotal in quality assurance processes. The introduction of quality assurance exemplars supports the focus on improving the quality of practice. Inspectors examined cases that had triggered 'practice alerts' highlighting issues of compromised practice, such as insufficient core group activity to progress child protection plans or not identifying fully the risks to a child. This system provides an effective layer of quality assurance though serves to highlight that there is further work to do to universally embed consistent and robust management oversight of team activity at the team management level.

80. The quality of social work supervision is variable with some poor and some excellent provision seen. Overall, the quality of supervision is adequate and improving. Staff expressed the view that there was increasing use of reflective supervision though agreed this is not always well evidenced on case files. Social workers spoken to during the inspection feel well

supported and have formal and ad-hoc access to their managers. Management oversight of cases is generally effective with managers giving clear case direction following supervision of their staff. Case directions are mostly responded to appropriately by social workers although there is more to do to ensure that work is well-targeted and focused on the protection and welfare needs of the child rather than the presenting needs of adults. Management challenge is increasingly used to improve assessment and planning for children and young people and is assisted by the use of external consultants who may sit alongside workers or 'floorwalk' in the role of social work advisors.

81. Parents report positively on the intentions and impact of the help they receive when involved in child protection processes where feedback is routinely sought and collated. Plans are well advanced to engage with a group of parents who are or have been involved in child protection services to inform service provision and act as a sounding board for new developments. Similarly the PSCB is to engage imminently with over 100 children and young people in the establishment of Young Peoples' Safeguarding Advisory groups that it is hoped will lead to the emergence of a shadow PSCB. Despite these recent developments, the council recognises that processes to seek and utilise feedback from children, young people and their families are underdeveloped and yet to display impact. An advocacy service for children involved in child protection is firmly in place although more is to be done to maximise the use and benefit of this service.

82. Complaints are monitored quarterly with evidence seen of issues being addressed appropriately. However, complaints are managed corporately and the most recent annual complaints report is overly focused on process. Whilst the nature of complaints is listed, these do not differentiate between children's and adults' services. Learning arising from the annual report is not evidenced as there is no action plan attached nor is there any evidence of progress made in relation to issues arising from the previous annual report.

83. The council has made significant investments in workforce planning and has reduced its reliance on agency staff by successful recruitment campaigns. Since January 2012 the priority has been to increase the permanent social work establishment resulting in vacancies covered by agency staff being reduced from 31% to 13%. The council monitors the diversity of the workforce but has not proactively targeted their recruitment to reflect the increasing diversity of the local community. Support to newly qualified social workers (NQSWs) and training opportunities to other key staff including first line managers is valued and positive. However, although feedback from staff in relation to their experiences of training is routinely gathered, the council is aware the systems for assessing the longitudinal impact of learning on practice are underdeveloped.

84. The council has developed good links with educational establishments. However, in order to achieve a well-balanced range of experience within social care teams, the council has made a judicious decision to cap, at 20%, the number of newly qualified social workers within the children's social care workforce. The role of the advanced practitioner is being developed to support social work practice as well as to retain staff through career development. Professional development reviews are routinely undertaken with completion compliance at 95%. However, they are not yet being fully utilised to feed into training plans to ensure training is targeted to need.

Record of main findings

Local authority arrangements for the protection of children	
Overall effectiveness	Adequate
The effectiveness of the help and protection provided to children, young people, families and carers	Adequate
The quality of practice	Adequate
Leadership and governance	Adequate

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