Inspection of safeguarding

Peterborough

Inspection dates: **08 August 2011 to 12 August 2011**
Reporting inspector **Martin Ayres HMI**

Age group: All
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Contents

About this inspection

1. Peterborough received a safeguarding and looked after children inspection in March 2010 which found that the safeguarding arrangements were inadequate. In February 2011 an unannounced inspection of Peterborough Council's contact and referral arrangements found some areas of improvement from the earlier inspection although 10 areas for development were identified. The purpose of this follow up inspection of safeguarding is to evaluate the progress and contribution made by relevant services in the local area since the previous inspections towards ensuring that children and young people are properly safeguarded. The inspection team consisted of three of Her Majesty's Inspectors (HMI). The inspection was carried out under the Children Act 2004.

2. The evidence evaluated by inspectors included:

   - discussions with children and young people receiving services, front line staff and managers, senior officers including the Chief Executive of Peterborough Council, the Executive Director of Children's Services and the Chair of the Local Safeguarding Children Board, elected members and a range of community representatives

   - analysing and evaluating reports from a variety of sources including the Improvement Board minutes, performance data, information from the inspection of local settings such as schools and daycare provision, and the evaluations of serious case reviews undertaken by Ofsted in accordance with *'Working Together To Safeguard Children'*, 2006

   - a review of 40 case files for children and young people with a range of need. This provided a view of the quality of services provided as well as the quality of reporting, recording and decision making undertaken

   - the outcomes of the most recent annual unannounced inspection of local authority contact, referral and assessment services undertaken in February 2011

   - interviews and focus groups with front line professionals, managers and senior staff from NHS Peterborough and other relevant health partners.

The inspection judgements and what they mean

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

Outstanding (Grade 1)	A service that significantly exceeds minimum requirements
Good (Grade 2)	A service that exceeds minimum requirements
Adequate (Grade 3)	A service that only meets minimum requirements
Inadequate (Grade 4)	A service that does not meet minimum requirements

Service information

4. The demography of Peterborough is rapidly changing. There are 44,300 children and young people aged 0 – 19 years in the council area with 24% of this population living in poverty. There has been a particularly high influx of families from Eastern Europe but other cultures and ethnic groups are represented in the city. Within the current child population 99 different languages are spoken and 27% of school pupils have English as their second language. There are marked differences in the levels of deprivation and affluence in Peterborough with some wards represented in the highest quartile of deprivation and others in the top quartile for affluence.

5. Peterborough Safeguarding Children Board (PSCB) has been independently chaired for the last year and brings together the main organisations working with children, young people and families to deliver safeguarding services. The Children's Trust operates with suitable representation from a wide range of agencies and organisations. This is currently being reviewed in light of anticipated changes to Trust arrangements.

6. Community based services are delivered by a number of social work teams. A contact service within Peterborough customer services has recently been formed and this is linked to referral and assessment teams and other longer term and service delivery teams. Children with disabilities are supported through a dedicated disability team and there is a range of additional family support services provided by the voluntary sector, extended services in schools and through children's centres across the city. At the time of the inspection there were 161 children who were the

subjects of child protection plans and 321 who were being looked after by the local authority.

7. Commissioning and planning of health services are provided by NHS Peterborough. Acute hospital services are provided by Peterborough and Stamford Hospitals NHS Foundation Trust. Child and adolescent mental health services (CAMHS) are provided by Cambridge and Peterborough Foundation Trust. Targeted mental health in schools services are provided by Peterborough City Council. Other services such as alcohol and substance misuse services are commissioned from the voluntary and independent sector.

Safeguarding services

Overall effectiveness Grade 4 (Inadequate)

8. The overall effectiveness of services in Peterborough to ensure that children and young people are safeguarded and protected is inadequate. There are areas of adequate, and in some instances better, practice across the partnership, including within education, health and the voluntary sector. Nonetheless, serious deficiencies in the social care fieldwork service result in too many children and young people being left without sufficient safeguards or adequate protection arrangements. Safeguarding awareness across the partnership is generally good and agencies are appropriately identifying children and young people who may be at risk of harm. Arrangements within schools for safeguarding are suitably robust and processes in health are also effective. However, in many of the cases seen by inspectors within children's social care there are significant concerns about the quality of practice and management oversight and some instances where children and young people have not been adequately protected.

9. The safeguarding inspection which was undertaken in March 2010, leading to a judgement that the overall effectiveness of safeguarding was inadequate, identified a number of key issues for immediate action and improvement. Many of these issues were also identified in the subsequent unannounced inspection of contact, referral and assessment arrangements in February 2011. These included variations in the quality and timeliness of assessments, poor management oversight and direction, irregular staff supervision and support and lack of responsiveness to risk in some cases. This inspection has identified a number of similar issues and trends which have not been fully confronted or resolved throughout the period the council has been subject to a Government Improvement Notice. In effect it is not possible to be assured that the current situation in children's social care services has sufficiently improved to ensure vulnerable children and young people are safe.

10. Leadership and management, including performance management and quality assurance, have not been sufficiently well focused to bring about sustained improvements and some aspects of performance have deteriorated in recent months. Staffing capacity is insufficient at the front line of service, in terms of staffing numbers and also skills and experience. This is compounded by insufficiently clear management accountability for safely driving forward work on individual cases. Progress has been made in establishing the PSCB which is now operating, under an independent chair, in an adequate manner.

Capacity for improvement Grade 4 (Inadequate)

11. Capacity for improvement in Peterborough is inadequate. Given the number of unresolved issues identified in previous inspections, the Government Improvement Notice and lack of progress made against agreed priorities, it is not possible to see sustained improvement. Services are not generally of a high quality. Some aspects of service delivery have deteriorated, including timeliness of initial and core assessments. Although some plans have been put in place to strengthen services and there are examples where this has had a degree of impact, for example work allocation, many changes have been reactive to day to day crises. Senior managers in children's services have not implemented a coherent and systematic plan which is based on clear priorities and expectations in terms of staff capacity, accountabilities and competence. The recent contact service development is an example where a real opportunity existed for service improvement which has been hindered by the lack of effective pre-planning and preparation to ensure the service was established on a sound footing.

12. A performance monitoring framework and model for auditing are in place but these are insufficiently focused on service quality, impact and outcomes for vulnerable children and young people. The information provided to the improvement board has been insufficient in facilitating the close scrutiny of actual performance, particularly in respect of the effectiveness of contact, referral and assessment arrangements.

13. Staffing resources are not yet sufficient to deliver safe and reliable services and level of staff turnover is still creating actual and potential risk. Staff competency and skill is also highly variable and management action to deal with perceived deficiencies has been too slow. There is only minimal evidence that children and young people are contributing to their plans and some of the systems in place actually limit their effective involvement. The current recording system in use in children's social care, although being replaced, is not fit for purpose and it will be some time yet before the new system is fully functional with the capacity to provide reliable performance information.

14. Despite the concerns about capacity, elected members have demonstrated a consistent and sustained commitment to strengthen safeguarding arrangements in Peterborough, including the allocation of additional resources. There is assurance that this commitment will continue as the council and partners respond to the recommendations arising from this inspection.

Areas for improvement

15. In order to improve the quality of provision and services for safeguarding children and young people in Peterborough, the local authority and its partners should take the following action.

Immediately:

- Review staffing and management capacity within the contact service to ensure the service is able to respond to the range of contacts and referrals in an informed manner. The review should also evaluate the potential for closer working with the Police and health colleagues to increase the effectiveness of contact arrangements.
- Ensure that the work required in respect of risk assessment and report writing are completed before cases are presented to case conferences and that work with families is not delayed until the conference is held.
- Ensure that thresholds for service access are clearly understood across the partnership.
- Define the use of contacts and referrals by referring agencies, the standard of recording of contacts and referrals and the process for decision making in respect of each and the actions arising.
- Ensure that management accountabilities for decision making are explicitly defined so that actions in relation to contact, referral, assessment and care planning are clear and consistently implemented.
- Strengthen the use of the performance monitoring framework and audit tools to ensure that service quality, service impact and safeguarding outcomes are routinely evaluated and reported to the Improvement Board.
- Establish a monitoring framework for work flow between contact, referral and assessment teams and subsequent teams to ensure work transfer is timely and conducted in the interests of children and young people.

Within three months:

- Complete an evaluation of staffing capacity within the contact centre, referral and assessment and other teams to ensure staff working in these services are sufficiently experienced and have adequate support to respond to need and risk appropriately.
- Facilitate the engagement of users in case conferences through more user friendly conferencing arrangements.

- Monitor the frequency and quality of staff supervision and ensure that remedial action is taken where required.
- Monitor the quality of management decision making and ensure case decisions and plans are routinely recorded and fully supported by a clear management narrative.
- Develop specific joint training on risk identification and issues associated with the potential for significant harm.

Within six months:

- Complete a comprehensive and detailed audit of all cases that have been referred through the contact service and passed to referral and assessment and other teams or services in the past six months. As part of the audit also examine whether cases referred to children in need services are appropriately held within that service.
- Develop an overarching preventative strategy, including the use of the common assessment framework (CAF).
- Review the current arrangements for jointly managing domestic abuse cases to ensure notifications are sufficiently comprehensive, joint assessments of risk are robust and actions arising are appropriately implemented and monitored.
- Review capacity within the Family and Assessment Support Team (FAST), to ensure that the threshold for access to this service is safe and clear and that processes for reviewing the team's impact on outcomes are explicit.
- Strengthen processes for user complaints and representations to ensure these are dealt with in a timely fashion and that complaint trends are regularly reviewed and acted upon.
- Complete a review of arrangements for the notification and referral of domestic abuse to ensure improved consistency of response and quality of outcomes for children at risk of harm.

Safeguarding outcomes for children and young people

Children and young people are safe and feel safe

Grade 4 (Inadequate)

16. Safeguarding outcomes for children and young people are inadequate. Inspections of safeguarding arrangements, either unannounced or

announced, which occurred in August 2009, March 2010 and February 2011 all identified significant weaknesses in child protection and safeguarding services. Despite the provision of these findings and the active work of an Improvement Board there is insufficient evidence of sustained improvement in key aspects of practice, and in particular the performance of children's social care services. The safeguarding and child protection needs of children and young people in Peterborough who require social care intervention are not adequately identified and responded to in a timely way. Cases scrutinised by inspectors indicated considerable variation in the quality of practice and management oversight leaving some children and young people at risk of potential harm. In a significant proportion of these cases children and young people who were judged to be vulnerable did not have their safeguarding needs fully recognised or acted upon in a timely manner. Evidence from case file audits indicates that some assessments, even when completed, are not robust enough and do not sufficiently evaluate risk and protective factors. For example, in one case seen the assessment did not cover the safeguarding issues that had been identified from the referral that an adult had physically abused the young person. This was completely overlooked in both the assessment and in case management oversight. It is of concern that the quality assurance audit undertaken within children's social care judged this assessment to be good.

17. A lack of focus on risk and protective factors in initial and core assessments, with a significant number not completed within timescale, has inevitably resulted in some children and young people drifting in the system without explicit plans for their protection in place. For example, in one case seen by inspectors it has taken a year for a young person to be transferred into the children in need team to enable him to receive the appropriate services to meet his needs. The percentage of initial and core assessments completed within timescales has deteriorated following a period of progress in 2010. In June 2011 there were 153 open initial assessments with 114 out of timescale and 127 current core assessments with 57 out of timescale. In August 2011 there were 108 open initial assessments with 74 out of timescale and 137 core assessments with 42 out of timescale. Slippage in timescale is extensive and in some recent cases ranges from 40 to 106 days overdue. In some cases seen assessment templates were apparently being used as recording tools, with episodes remaining active for several months while assessments were ongoing, without an effective plan in place to meet the child's needs. Decisive action is not consistently being taken in respect of some children and young people who have been subject to child protection strategy discussions and where a decision has been taken for the case to go to an initial child protection case conference. In a few of these cases the conference was not convened and no core assessment was completed.

18. Until recently there has only been one permanent team manager in the referral and assessment service in post and this has adversely affected the

quality and extent of management oversight of social workers' caseloads, decision making and supervision. An agency team manager is now temporarily covering the post which remains vacant. Steps have been taken to reduce social workers' caseloads and these are now more manageable. However, the quality of practice remains too variable and managers are often stretched to provide the support needed, particularly for newly qualified social workers, in working with challenging and demanding cases. There have been marked fluctuations in fieldwork staff capacity with vacancy rates between 11% and 15% at various times during 2010-11 and in May 2011 they were at 14%. Caseloads are reducing towards the average target of 25 per social worker. In June 2011 six staff had caseloads above 25 with two staff having 30. During the last six months there have been occasions when there have been no team managers available in the referral and assessment team leading to a range of cover arrangements for staff support. FAST, which undertakes direct work with children and families and some 'safe and well' checks when required, has been significantly affected with the reduction of 11 resource worker posts. There is an acting team manager in post in this team and the service is also carrying two assistant manager vacancies which have not been filled for a significant period of time. The team is currently unable to absorb any new work and 35 families are awaiting an appropriate service. This is having a direct impact on the work of referral and assessment teams, as social workers now have to undertake some family support tasks in addition to their core assessment and protection duties. For example, in one case seen the work on an assessment to determine the viability of a child returning home to live, which would formerly have been allocated to a FAST worker, had taken over five months to complete with the child waiting in a foster placement throughout this period.

19. The current electronic recording system is not fit for purpose. It is not user friendly and is slow to respond with the result that social workers complete their work on separate templates. This can lead to different versions of key documents appearing on the electronic and paper versions of the file with the risk of children's needs being misrepresented, if the paper file is not available or consulted. A comprehensive commissioning exercise has been undertaken which included consultation with social workers and a replacement system is in the process of being implemented. However, it is unlikely that the replacement system will be fully embedded with capacity to provide good quality performance information for another year.

20. The role of the Local Authority Designated Officer is adequately understood and statutory guidelines in relation to complaints made against staff working with children and young people are satisfactorily carried out, with appropriate reporting mechanisms in place to the Local Safeguarding Children Board. Processes to ensure safe recruitment of staff are adequate. The council's existing recruitment practice is safe and is

continuously reviewed and updated. A recent internal audit of recruitment arrangements indicated that these were adequate.

21. Children and young people met during this inspection confirmed that they generally felt safe in the community. There is a strong corporate commitment to community cohesion and safety exemplified by recent proactive work to respond to the potential for riots witnessed elsewhere in the country. Action taken was comprehensive and young people worked well with the Police to communicate positive messages using social networking sites which clearly had an impact in maintaining calm and order in the city. A good anti-bullying strategy (Becoming Brave) promotes the use of mentors, buddies and the provision of support for children and young people who may be witnessing parental domestic violence at home. Satisfactory arrangements are in place to identify and monitor children missing from education and care and children educated at home. A robust missing from school protocol has been developed and is currently the subject of consultation within the partnership.

22. Safeguarding in schools has been judged mostly good and some outstanding by Ofsted inspections. All schools, including faith schools, have designated and trained safeguarding staff. There is good awareness of safeguarding within schools leading to appropriate contacts and referrals to social care services. The adoption service was inspected in March 2011 and was satisfactory overall with staying safe judged good. The fostering service was last inspected in 2008 and was judged overall as satisfactory with staying safe as satisfactory. One children's home has been judged as good and two as outstanding.

Quality of provision Grade 4 (Inadequate)

23. The quality of provision is inadequate. Thresholds are defined within a vulnerability matrix to enable referring agencies to make consistent decisions about contacts and referrals to children's social care services. Although the matrix is conventional in design some confusion remains about its interpretation among some referring agencies and professionals regarding its use and specifically what constitutes a contact or referral. In July 2010 the Improvement Board considered the issue of contacts not being filtered out from referrals. However, this matter does not appear to have been fully resolved as it is reported in the Performance Management meeting a year later that there was a need for practitioners in the contact centre to receive additional training on thresholds as they were recording referrals on the system when they were in fact contacts. Additionally, some of the referring agencies raised the issue with inspectors about their ability to make appropriate referrals as opposed to contacts and the consistency of decision making in respect of referrals in the context of changing work and staffing pressures in children's social care. The lack of

clarity in respect of contacts and referrals also presents challenges in the way the level of referrals is being recorded and the current accuracy of referral data. An escalation policy and process was established in December 2010 which has provided some reassurance to referring agencies that cases can be quickly identified when there are perceived deficiencies in social care or other action. However, this process is not a replacement for sound risk assessment and decision making in the first instance.

24. The council has established an effective customer contact service to deal with incoming enquiries and contacts in respect of the range of council services. This service is well managed and ensures a timely response to members of the public. As part of this overall service children's services have recently located a team manager and other staff within the customer contact service to process incoming contacts and referrals to children's social care including safeguarding. However, the way the children's service component of this customer contact service has been established is not sufficiently safe or robust. When the decision was taken to locate children's social care staff within the broader customer services function there were known management and staffing capacity problems in children's social care which impacted on the implementation and subsequent effectiveness of the service. These difficulties persist and have not been fully resolved. Capacity issues remain within this service and there is a lack of clarity about accountabilities for decision making and how planning decisions and actions are agreed between this part of the service and referral and assessment service. Inspectors found several cases where referrals, signed off by the team manager, were not always followed up once the work was allocated to a social worker in the referral and assessment service. The quality of domestic abuse notifications from the Police is too variable and arrangements for dealing with high levels of domestic abuse cases have not been fully developed. Responses to domestic abuse cases have been too inconsistent and given the nature of some notifications a potential high risk remains.

25. There are some effective services in place for early intervention and prevention. For example a children's centre seen during the inspection provided a broad range of preventative services to families in a high quality physical resource. The council has good commissioning arrangements in place with a variety of voluntary organisations to provide family support at a number of children's centres. This works well and significantly enhances the outreach capacity of the centres to vulnerable families with younger children. For the older age group, targeted youth support services offer one to one sessions with designated staff, in addition to a range of support activities such as the summer activities scheme for children who are identified as requiring additional support. The CAF is being used but there is some concerning evidence to suggest that there is too great a reliance on this form of support when some cases should have been dealt with much earlier through child protection

processes. The PSCB has identified the inappropriate use of the CAF tool as a referral form to children's social care instead of its primary function in facilitating 'team around the child' approaches. This point was also identified through a recent audit of arrangements for identification of concern about unborn babies. There is positive feedback on the use of the CAF by midwives and some schools but there is low use by children's centres. Overall, there is too little firm evidence of the impact of CAF in improving outcomes for children, young people and their families. The purpose and position of the CAF within preventative services and the use of the range of services by agencies and professionals are insufficiently clear.

26. The quality and timeliness of initial and core assessments remains too variable. Some assessments are adequate and a few good but others contain minimal or no information. From the records seen by inspectors it was possible to confirm that children and young people were seen as part of some assessments but too frequently it was impossible to ascertain whether their views and feelings had been appropriately taken into account in their plans. A number of children and young people who should have had children in need plans had no such plans in place. Others, who were the subject of children in need plans, should have been safeguarded through child protection processes. Child protection core group meetings are not always regular and there is often a delay in minutes being typed and placed on the electronic recording system. Records demonstrate that case supervision has been infrequent and insufficiently rigorous. However, social workers report that they now receive more regular supervision during which work is examined and challenged, leading to some adjustments to plans where appropriate. However, staff and managers have acknowledged this is only a recent development.

27. Out of hours arrangements are satisfactory and commissioned through an emergency duty service provided by Cambridgeshire County Council. Strengths of the service include the availability of designated Peterborough foster carers so that where children are in need of care this can be provided immediately. Social workers from the service report good relationships and joint working with the Police. However, the service is working very remotely from Peterborough and is highly dependent on access to up to date and comprehensive electronic records when safeguarding issues are raised. The effectiveness of the service is considerably reduced because record keeping in children's social care is inadequate. There are too many gaps in case notes and a general absence of recording of key management decisions such as changes to original decisions taken by the manager in the contact centre in the ongoing processing of referrals. Although the practice of recording on only one child's electronic file ceased in April 2011 inspectors found some inconsistencies in current cases resulting in key information on siblings not being readily accessible out of hours.

28. There has been a marked improvement in the allocation of cases to social workers and there are currently no unallocated cases. All cases seen were allocated appropriately to a qualified social worker. Caseloads are high within the referral and assessment team and a reduction in the capacity of other services, such as FAST, to support social workers is leading to delays in the completion of work. In turn, this has a negative impact on the numbers of cases social workers are holding and the overall efficiency of teams. All child protection assessments are allocated immediately to suitably qualified staff although there is still a reliance on newly qualified staff to undertake complex tasks. The quality of assessments seen by inspectors was highly variable. Some assessments recorded on the system are insufficiently detailed and there are discrepancies in detail between paper and electronic files. Significant delays, in some cases of several months, were noted in the completion of assessments and provision of services while further information is being sought. Management decision making is not always clearly recorded although there is some recent evidence of improvement. Assessments do not always involve partner agencies and some have commented that they find it hard to get involved in work once referrals have been made. There is no formal process in place to undertake welfare checks on children and young people referred for an assessment. Inadequate and inaccurate assessments have resulted in re-referrals or in plans for children drifting, with the consequence that substantial resources have to be expended later on formal statutory intervention that might have been prevented had interventions been more timely and based on clearer assessments of need and risk.

29. Peterborough has a diverse population with 99 different languages spoken and 27% of school pupils with English as a second language. The council and partners have been responsive to the challenges of child poverty and diversity and ensured there is a range of resources in place to identify needs including translation and interpretation services together with specialist provision such as effective educational support for the Traveller community.

Ambition and prioritisation Grade 4 (Inadequate)

30. Ambition and prioritisation is inadequate. Elected members demonstrate ambition and commitment to securing effective safeguarding services in the city. To this end they have provided additional resources to children's social care and have stated that further resources are available if required. However, the analysis of staffing and managerial capacity is insufficiently robust and elected members have not had the opportunity to fully understand or address this issue in a comprehensive manner. This is particularly the case with the current service pressures, changes in service organisation such as the introduction of a contact service, and the lack of analysis of the impact of preventative services in improving outcomes for vulnerable children and young people. The Improvement Board, chaired by the Chief Executive, has appropriately challenged aspects of

performance in children's social care but the information provided has been too limited to facilitate close scrutiny of actual performance, particularly in respect of the effectiveness of contact, referral and assessment arrangements. The issues identified through this inspection demonstrate that there are several factors which have reduced the effectiveness and pace of improvement to ensure that children and young people are adequately protected from the likelihood of harm.

31. Safeguarding policies and procedures are in place and there is good awareness of safeguarding across the partnership. PSCB is now operating at an adequate level and recently developed a good business plan. Information sharing protocols have been established but issues of information sharing and effective joint working at a case level remain a challenge. Vulnerable groups are identified within the city with evidence of some effective targeting to meet identified needs. A recent needs analysis is comprehensive and provides good quality data on local needs in the community. However, prioritisation of action has been inconsistent and in some instances too slow with too much reliance on aspects of preventative services without suitable measures in place to evaluate individual and collective impact and outcomes.

32. Senior managers in children's social care have developed a vision for services based on a model 'Making everyday count' but this has not yet been implemented. Some staff within children's social care did not have understanding of the ambition and vision being promoted by senior managers. Priority setting has been reactive to crises as opposed to finding ways to confront and resolve fundamental problems and sustain improvement over time. Accountabilities are not always clear or effective, particularly in the key area of the contact service, referral and assessment and assessment and care planning.

Leadership and management Grade 4 (Inadequate)

33. Leadership and management are inadequate. Leadership within children's social care is not yet sufficiently secure to ensure that children and young people are adequately protected. Senior managers have not fully confronted or resolved significant issues identified through previous inspections and the pace of improvement has been too slow and in some aspects ineffective.

34. Some progress has been made in developing a suitably skilled and experienced workforce through the workforce plan but staff turnover within front line services has been high and the vacancy rate is currently 14%. Newly qualified social work staff are not consistently being given the level of supervision and direct management support they need to undertake challenging work because their line managers are too often over-stretched, have other cover responsibilities and do not have the capacity needed to monitor and track the quality of practice and outcomes

for vulnerable children and young people. These inconsistencies have been identified clearly through inspection and through audits undertaken within children's social care. They include inadequate management oversight and sign-off, inconsistent assessment quality and timeliness, case recording and responsiveness to changing needs and risks. Several cases examined in the course of the inspection exhibited features which strongly reflected earlier inspection findings. Action plans derived from serious case reviews have been developed but these have not had sufficient impact in changing practice in respect of risk identification and analysis, or the quality of management oversight and decision making and safe application of thresholds in response to concerns raised by referring agencies and professionals.

35. The lack of staff and management capacity in children's social care services is also reflected in the variable quality of work presented to case conferences. Some cases seen by inspectors were of a good standard but other cases were inadequate and not ready for presentation to a conference. This illustrates a lack of management oversight in allowing cases to go forward when basic elements of work have not been fully completed. In turn, this has placed a pressure on conference chairs to use conferences to undertake aspects of work that should have been completed earlier or to offer staff advice and guidance outside of their remit. Conference chairs undertake their duties and responsibilities with suitable rigour, but their capacity is stretched and roles and accountabilities in respect of decision making are too often unclear because of the pressure on first line managers. The absence of senior practitioners within the service places an additional burden on first line managers in supporting less experienced staff with their work, increasing assessment and care planning capacity and helping to monitor the quality and impact of services to support vulnerable children, young people and their families.

36. The complaints service is not fully embedded with significant reported delays in dealing with complaints. Until recently over 50% of complaints were not processed within 20 days. Although this has now reduced to 13% the rate remains too high. The issues identified through complaints and representations strongly reflect the lack of staff and management capacity to engage service users at appropriate stages in assessments and care planning and opportunities are being missed to imaginatively support users through conference processes. Child protection coordinators who chair case conferences have clear proposals to improve the position but this is not yet part of a coherent and over-arching strategy for effective user engagement which takes into account service demands and capacity. It is significant that the annual complaints report 2010-11 confirmed that delays and poor service were identified in several of the complaints that were escalated to Stage 2 although only one of the cases was fully upheld.

37. PSCB now operates at an adequate level. The business plan is good and provides impetus for the continued development and improvement of the board. Agency commitment to promoting safeguarding awareness across the city is also good and underpinned by a wide range of accessible inter-agency training and publicity material. Leadership and management of safeguarding within schools is good overall with some outstanding examples of effective practice. Safeguarding leadership and management within health provision is at least adequate and arrangements for the identification of children and young people who are at risk are established and consistently implemented. Cambridgeshire Police are appropriately engaged in PSCB and demonstrate good responsiveness to individual case issues and to strategic planning. The Police have identified opportunities for improved service integration with children's social care but to date these have not been actively pursued.

Performance management and quality assurance
Grade 4 (Inadequate)

38. Performance management and quality assurance are inadequate. A performance monitoring framework has been established which provides information to the Improvement Board and PSCB on key aspects of performance and in the form of quantitative data such as referral and assessment rates and timeliness. However, the provision of information on the quality of work, the impact of services on safeguarding outcomes has been too limited. The achievement of some performance targets set by the improvement process has been inconsistent particularly in respect of assessment processes and timescale. Information derived through the recording system is not fully reliable, particularly in respect of rates of contacts and referrals and timescales for work completion. The Improvement Board has appropriately challenged the degree of progress being made and from time to time sought additional information and clarification. However, the lack of focus on quality and outcomes has served to reduce the effectiveness of the improvement process and led to an unwarranted degree of over-optimism about actual performance in keeping vulnerable children and young people safe. Although this inspection has identified pockets of good practice this has been dependent on individuals as opposed to having in place a systematic process managing and developing performance at all levels and assuring quality within the contact service and assessment and planning teams. The contact service within customer services was established without a specific performance management and quality assurance framework to measure work flow, quality and decision making. This is a significant deficit.

39. A process and framework for auditing cases is now established. This has been supplemented by a thematic and multi-agency audit undertaken by PSCB in respect of unborn babies who may be at risk because of previous family concerns. Although audits have been completed which identified

many of the issues raised in the course of this inspection they have not consistently resulted in appropriate timely actions being taken. Additionally front line managers have not always had sufficient capacity to undertake auditing tasks. Audits undertaken by children's social care staff of the cases randomly selected by inspectors reported issues in most cases. These included inadequate initial and core assessments, lack of follow up of agreed actions and delays in assessments and service provision. However, it is of significant concern that in some instances auditors had recorded work as being good although aspects were clearly inadequate. In effect, qualitative management information is insufficiently developed and in some cases unreliable. Consequently it is not being used effectively to deliver continuous improvement and to sustain high quality safeguarding and child protection services.

Partnership working Grade 3 (Adequate)

40. Partnership working is adequate. PSCB is now fulfilling its statutory function and providing adequate leadership. Attendance by partner agencies is good with evidence of commitment to improving safeguarding outcomes. The last serious case review undertaken in Peterborough was judged by Ofsted to be adequate. A serious case review has recently been commissioned and is due to be published in October 2011. Inspectors received a briefing on the key features of this case many of which appear to mirror key findings in this inspection. Arrangements for joint commissioning of services are effective with a good focus on safeguarding within provider and commissioned services. Partnership working at an individual case level is less consistent although there are some good examples of effective joint work in respect of 'team around the child', school responsiveness to concerns and some aspects of health provision. The Police commitment to partnership working is manifest and opportunities exist to integrate first response services although this option has not yet been actively pursued by children's services.

Record of main findings:

Safeguarding services	
Overall effectiveness	Inadequate
Capacity for improvement	Inadequate
Safeguarding outcomes for children and young people	
Children and young people are safe and feel safe	Inadequate
Quality of provision	Inadequate
Ambition and prioritisation	Inadequate
Leadership and management	Inadequate
Performance management and quality assurance	Inadequate
Partnership working	Adequate
Equality and diversity	Good

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