CREATING OPPORTUNITIES AND TACKLING INEQUALITIES	AGENDA ITEM NO. 8
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Report of the Corporate Director for People and Communities

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SERVICE DIRECTOR AND PORTFOLIO OVERVIEW REPORT: CHILDREN & SAFEGUARDING

1. PURPOSE

1.1. This report provides an overview of the key activities within the portfolio of the Service Director for Children and Safeguarding, as well as providing a summary of key performance information in respect of Children's Social Care.

1.2. The key performance information is accompanied by narrative and where possible, performance is compared with statistical neighbours. However, there are a number of areas where such comparisons are not available or are comparing comparator performance with data that is from 2013/14. Most comparative data for 2014/15 will not be available until December 2015.

2. RECOMMENDATIONS

2.1. Committee is asked to note the contents of this report, and to consider whether there are other areas of performance on which regular reports would assist the work of the Committee.

3. LINKS TO THE SUSTAINABLE COMMUNITY STRATEGY

3.1. Creating Opportunities - Tackling Inequalities

- Supporting vulnerable people

4. BACKGROUND

4.1. The Service Director for Children and Safeguarding is accountable for a number of areas of service delivery as follows:

- Children's Social Care Services, with the exception of services to children and young people with disabilities, which is provided by the 0-25 Service within Adult Social Care services;
- The Child Health and Healthy Child programme and associated commissioning arrangements;
- Oversight of the Joint Business Unit that supports the operation of the independent multi-agency Safeguarding Children and Safeguarding Adults Boards, and;
- Quality Assurance functions within Children's Social Care. These functions are likely to be combined with quality assurance functions for Adult Social Care in due course, with

the responsibility for the resulting joint unit remaining with the Service Director for Children and Safeguarding.

4.2. Since the 1st November 2015, the Service Director for Children and Safeguarding has acquired line management responsibility for our two short break/respite homes [Cherry Lodge and The Manor] for children and young people with disabilities and the associated outreach and community breaks services that these provisions also offer.

Children's Social Care Services, including key performance information

4.3. Since the last Service Director report was presented in July 2015, the OfSTED inspection report has been published.

4.4. The OfSTED report identified a number of areas of strength in our services, including early help and adoption. However, the impact of turnover of staff, variable quality of assessment and care planning and limited real time performance management systems, combined with a [at the time of the inspection] very recently appointed senior leadership team, led to an overall finding that the 'service requires further improvement in order to be good'.

4.5. The findings of this inspection were broadly in line with the self-assessment that we had completed as a new management team appointed in March 2015. This was very helpful, given that the unannounced inspection commenced in April 2015.

4.6. A detailed internal service improvement plan has been in place since the inspection process came to an end. An improvement seminar led by OfSTED is taking place on 9th November 2015, and this will also make any recommendations about the content of the formal draft OfSTED improvement plan, before this is finally signed off.

4.7. Progress is being made. For example, at the time of the inspection, the overall number of cases open to the service was almost 2,000. This high level of cases in the service, combined with continuing high levels of demand on the First Response Team had led to the Corporate Director seeking permission from the Chief Executive to implement a triage process, where referrals were triaged and those assessed as being of lower risk were not immediately allocated for assessment..

4.8. OfSTED recognised the action being taken to strengthen the assessment functions at the front door, and since the inspection, the overall number of children open to the service has steadily declined as all open cases have been reviewed by the Heads of Service. As of 19th October 2015, there were 1,720 cases open to Children's Social Care, and there has been no delay in allocating cases for assessment since June 2015. This number of open cases is more in line with longer term averages.

4.9. Caseloads in Family Support remain higher than we would like. This is why we have taken the initiative to appoint alternatively qualified team support workers. Their role will be two-fold; they will carry a caseload of less complex children in need cases and support the social workers in some of their direct work with families where children are subject to child protection plans.

4.10. This will improve the service to children with child in need plans, who can be seen as lesser priority when part of a large caseload that includes a number of children subject to child protection plans. A more focused response to children on child in need plans should lead to cases being open for shorter periods of time. This is better for the children, young people and their families concerned, but should also improve throughput, further reducing the number of children and young people open to the service at any one time.

4.11. Some changes have been made to the way in which court work is allocated within the service. All work is now undertaken within Family Support up to and including final hearings in care proceedings. Work used to transfer mid proceedings to the Children in Care service. This change has been made in order to reduce the numbers of social workers involved in managing the case and to give clear ownership and accountability for the quality and consistency of presentation of evidence and care planning to one service area.

4.12. This change, supported by the dedication of staff in the Children in Care Service, has contributed to an improved performance in terms of timeliness of visits to children in care. The fact that this part of the service no longer does court work means that scheduled visits are no longer likely to be cancelled because of an urgent court hearing.

4.13. Performance relating to timely visits to children on child protection plans is not yet good enough, however. This is in part related to the high caseloads in Family Support as noted above. It is also related to an increase in numbers of children subject to plans that took place in June and July 2015. This increase coincided with new managers joining the service. The numbers on child protection plans is reducing again, as can be seen from the performance charts in Appendix 1.

4.14. The following sections provide narrative to the charts that are reproduced in Appendix 1.

4.15. **Contacts, Referrals and Timeliness of Assessments**

4.16. There has been a period of variable practice in relation to the number of contacts that have progressed to referrals over recent months. This has in part been to do with changes within the Multi-Agency Safeguarding Hub [MASH] which resulted in more contacts appearing to be dealt with as referrals than has historically been the case. This is because the MASH process allows contacts to be open for up to 72 hours while they are being triaged, but the system assumes that any contact open for longer than 24 hours should be considered to be a referral.

4.17. The impact of these changes can be seen in charts 1, 2 and 3 in Appendix 1. Chart 1 shows the percentage of contacts converting to a referral. This was higher than target in June, July and August 2015 in particular. However, since a further review has taken place within the MASH hub, more contacts are being managed more quickly, and threshold decisions are being made in a shorter time. This has led to the reduction in the percentage of contacts being treated as referrals in September 2015, and the aim will be for this to continue. There is no statistical neighbour benchmarking available for this indicator. It is used locally as a means of helping to assess overall demands on the front door.

4.18. Chart 2 shows the rate of referrals per 10,000 population. The target for this has been amended recently to bring it in line with our statistical neighbour average, which makes the target more meaningful. The rate is showing a red indicator at present, which is also connected with the changes to the MASH Hub discussed above. As the percentage of contacts going on to become referrals reduces, this indicator will move in the right direction. However, because this is a 12 month rolling target, the impact of recent changes will take some time to feed through.

4.19. Chart 3 shows the percentage of referrals going to assessment, and is also showing that performance is currently rated red. This is again because of the much higher number of contacts that were opened as referrals in recent months which were then closed without proceeding to a single assessment. Performance in this area should stabilise and the

percentage of referrals leading on to assessments increase as the effect of the earlier months' of higher numbers of referrals works through the system.

4.20. The performance in these three areas all interlink. If more contacts progress to referrals then the proportion of referrals going to a single assessment will decrease. Getting the initial threshold decision correct in a timely way is the important issue here; if we are making good threshold decisions on the day, then the proportion of contacts progressing to referrals falls, and our staff in the MASH are spending less time making further enquiries to ascertain whether threshold for an assessment is or is not met.

4.21. This is the basis for work that is currently being led by the Peterborough Safeguarding Children Board to look again at our thresholds so as to reduce the amount of contacts being made to Children's Social Care. This is important because all contacts must be screened to ensure they do not include information about risks to a child. If we can move to a point where the generally accepted principle is that, except where there are indications of risks of immediate significant harm, support is offered at an Early Help level before contact is made with Children's Social Care, then our staff will spend less time making unnecessary enquiries.

4.22. Success in this area depends on a strong early help and prevention offer. Chart 3a in Appendix 1 shows the rate of early help assessments currently active per 10,000 children and young people in the City. Early help assessments are completed when it is identified that there is a need for more than one targeted service to work with the child and their family. These assessments are always completed with the consent of the family. Working alongside families in this way often leads to better outcomes than where an assessment is completed by Children's Social Care that recommends that the family accesses Early Help services. Chart 3a shows continuing increases in numbers of children being supported in this way, which is positive.

4.23. Where a referral into Children's Social Care is seen to warrant a further assessment, a single assessment is completed. These assessments should be completed within 42 days, and timeliness in this area is an indicator of the pressures on the system. Performance in this area is shown in Chart 4 of Appendix 1. The year to date target of 95% is a stretch target and signifies that there are high expectations in this area. The most recently monthly performance at 92.6% is in the amber range, although year to date performance remains red owing to poorer performance earlier in the year. As with other rolling 12 month indicators, it will take some time for performance to be above target before the indicator changes to amber and then green.

4.24. Chart 4a shows the position regarding the percentage of referrals where a previous referral has been made in the last 12 months. This indicator turned red in September, although the target was altered in the same month to 22% from 24%. This is an indicator that we are monitoring closely and may increase initially as thresholds are being applied more consistently. This is because it is more likely that children and young people will be re-referred if the more consistent application of thresholds means that fewer are accepted into the service as referrals than was previously the case.

4.25. This issue links to the overall number of children and young people being worked with by Children's Social Care. Earlier in the year, when numbers of children open to the service was as high as 2,000, the re-referral rate was much lower. This was not an indication of the system working as it should, however; it was an indication of the service accepting referrals of children that did not reach threshold.

4.26. The Children's Safeguarding Board will continue to work with partners on developing a better understanding of when and when not to refer to Children's Social Care through the work it is leading on the review of thresholds. This will support a decrease in re-referrals.

Safeguarding and Child Protection

4.27. The number of children becoming subject to child protection plans increased significantly over the summer months but is declining again now, although remains above target [see Chart 5 of Appendix 1]. The target has been revised so as to place the Peterborough target in line with statistical neighbour averages, as opposed to England averages. High rates of children subject to child protection plans are closely correlated to levels of deprivation and so a target in line with the average of our statistical neighbours is more realistic.

4.28. The higher rates in July and August 2015 appear to be related to threshold decisions in May and June of this year, when new managers began in First Response. This peak in numbers of children being recommended for an initial Child Protection Conference has happened before when new managers start, and are establishing themselves in new systems.

4.29. In theory, child protection conferences should apply consistent decisions and decide against making children subject to child protection plans where the threshold is not met. In reality, many agencies prefer children to be subject to child protection plans because they perceive these to have a better structure and, subject to more frequent review, when compared to child in need plans. This means that conference chairs can find themselves under pressure to agree to a child being subject to a plan; pressure that can be hard to resist.

4.30. In reality, having too many children subject to child protection plans has the potential to overload systems. This detracts from the service provided to those children and young people who really do need to be subject to a child protection plan.

4.31. In response to this issue, conference chairs and team managers have undertaken joint workshops to help them to apply thresholds for Child Protection plans more consistently and in line with previous practice, guidance and procedures. As a result, numbers on child protection plans are reducing again. The rate of 59.9 per 10,000 in September 2015 compares with a target of 53.6 per 10,000. This means that we currently have around 30 more children and young people subject to a child protection plan than we would expect when compared with our statistical neighbour average.

4.32. Chart 6 details the number of child protection review meetings that take place within timescales. The target for this has been changed form 98% to 100%, and current performance is good in this area. The most recent month always appears to show poorer performance because the system only recognises that a conference has taken place when the notes are uploaded onto the system. The notes from conferences held towards the end of the calendar month will be uploaded during the first few days of the following one, leading to the system to conclude that the conferences have not taken place in timescale. Once the notes are uploaded, the system recognises the conference has taken place, but this is not reported until the following month's report.

4.33. Chart 7 shows the timeliness of visits to children subject to child protection plans. This is an area where performance has not been consistently good enough for a considerable period, and is an area where there is renewed focus by team managers and heads of

service. There is strict criteria for what constitutes a statutory visit to a child subject to a child protection plan. This includes requiring the child to be seen alone and for the child's bedroom to be seen. Where the write up of a visit does not confirm these two things have happened, the visit is not counted as a statutory one.

4.34. There will always be a small number of visits that are not completed for a number of reasons. Examples include where families have moved abroad, have gone on holiday or are visiting relatives elsewhere and where families are refusing visits. The latter scenario is likely to lead to an escalation in the way the case is managed that may lead to legal proceedings being issued.

4.35. Most recent performance for September is that 92.2% of visits were carried out within timescale. The target has been revised upward to 98% from 95% as a stretch target to indicate the importance we are placing on performance in this area. The previous target of 95% would now attract an amber performance rating.

4.36. Performance in this area is expected to improve as we appoint the team support workers who will be able to absorb more of the child in need work from social workers within Family Support, enabling social workers to concentrate on driving forward plans for children subject to child protection plans.

Children Looked After

4.37. Chart 8 in Appendix 1 shows the rate of children and young people looked after per 10,000. Performance has been steady in this area for most of this calendar year and is in line with the target rate.

4.38. The rate of children and young people looked after in Peterborough is currently 73 per 10,000, which compares to the most recently available statistical neighbour average rate of 79.4. If Peterborough were in line with the statistical neighbour average, we would have an additional 28 children and young people in care.

4.39. Were our numbers to drop significantly from their current levels, it may indicate that we were not intervening effectively in families where children are at risk of harm. Were our numbers to rise significantly, it would indicate that we were probably bringing too many children into the care system. Numbers fluctuate slightly as children leave and become looked after, and what is the 'right' number to have in care is a difficult question as this is affected by a number of variables.

4.40. Overall anything between about 330 and 360 feels about right in the Peterborough context, where we have good performance in adoption and in achieving permanency through Special Guardianship Orders. This means that children are likely to spend less time looked after here than they may do in some other areas, which has the effect of reducing overall numbers. Indeed, research commissioned by the pan-London Safeguarding Children Board identified that the average length of time a child spent looked after had the greatest impact on the overall numbers in care in any one area.

4.41. Chart 9 shows the number of children and young people in care who have had three or more placement moves. We have revised the target for this indicator downwards slightly, and our current performance is now amber, with 10.3% of children having had three or more moves in the last 12 months. While this is still better than England or Statistical Neighbour averages [11.3% and 11.0% respectively], there has been an upward trend in the numbers of children who have had 3 or more moves in the last 5 months.

4.42. A figure for placement moves that is too low may indicate that thresholds for coming into the care system are too low. We would expect to be looking after a reasonable proportion of young people with challenging needs for whom identifying the right placement may take more than three attempts, for example.

4.43. Nevertheless, the trend in relation to this indicator will continue to be monitored over the coming months. If it continues to increase an audit will be undertaken to establish how performance can be brought back in line with the target.

4.44. Chart 10 shows the percentage of children looked after reviews that are completed within timescale. We have increased this target to 100% and current performance is 98.8%. This is an important indicator as anything other than high performance can indicate that a number of other features of the child in care system are not working effectively, and that the progress of children's care plans may be being adversely affected.

4.45. Chart 11 of Appendix 1 shows the timeliness of visits to children who are looked after. As with visits to children subject to child protection plans, there are a number of strict criteria around these visits that mean that simply seeing a child may not be enough to qualify as a statutory visit. The child must be seen alone, for example, and must be seen in their placement and not at another place such as a community facility or in school.

4.46. Performance in this area is currently broadly good and most recent performance – at 97.6% - is above target. There have been some months recently where performance was much less good.

4.47. This issue has been addressed in that there has been a move out of the service of court work, meaning that social workers in the Children in Care service no longer have to cancel visits to children because they have suddenly been ordered to attend court. This reorganisation of work means that the workers in this part of the service are able to focus on their work with children and young people who are looked after.

4.48. The percentage of Initial Health Assessments completed within 20 working days can be found at Chart 12 of Appendix 1. This is a very complex indicator for the current system to calculate accurately and the figures in this dataset are not correct. Performance is still too low in this area, with the most accurate figure that we have for September 2015 being that 55% of assessments were completed within timescale.

4.49. This is a difficult indicator to measure because a number of children who become looked after in any month may not remain looked after for more than a few days. The system records them as having been looked after in the month, but because it is unable to identify that a completed health assessment has taken place, shows them as not having had such a check, where the reality is that they would not require one.

4.50. Arranging an initial medical requires parents to provide written consent that must be supplied to colleagues in the Looked After Children's health team; without that consent, an appointment cannot be arranged. Once an appointment is arranged, the child has to be willing to attend and the foster carers able to take them on the due date. This is quite complicated when the child is in Peterborough but is even more so when the child has moved out of area. In this situation, our local health team do their best to prevail upon local health services to carry out checks within timescales, but the receiving area has their own children looked after and not all areas place the same priority for health assessments on children from other areas.

4.51. Another area for caution in relation to this indicator relates to the relatively small numbers involved. Where 10 children are looked after in any one month, with four coming from one family and where there is an issue in obtaining written consent, performance will drop to 60% at best for that month.

4.52. Despite the apparent low performance in this area, it is substantially better than in the last financial year where the average was around 20%. This follows new arrangements that were put in place in April this year to improve communication between Children's Social Care and health partners, following additional investment by health partners in clinic capacity to meet need. There remains a considerable distance to go before we can claim good performance in this area.

4.53. Chart 13 of Appendix 1 shows a more positive story however; this illustrates the proportion of children looked after for 12 months who have had a medical assessment in the previous 12 months. Current performance is 93.7% which rates as amber but only because we have raised the target from 85% to 95% in order to continue to stretch performance.

4.54. Chart 14 of Appendix 1 shows the proportion of children and young people looked after who have Personal Education Plans. Current performance is showing a dip compared with performance earlier in the year. In part this is because for those who have come into the care system over the summer, there is an obvious lack of school staff available to advise on completion of the plans.

4.55. This is an area where attention will be focused on the coming months, not just in relation to the percentage of children who have these plans, but also in relation to their quality and the extent to which they set measurable goals that have reflect a high aspiration for education and learning goals.

4.56. The Assistant Director is to establish a multi-agency performance board that will monitor and improve performance for our children in care. This board will increase oversight on areas such as improving educational outcomes, ensuring that information from child health assessments is captured so that it can be used in commissioning decisions and future service planning.

4.57. Chart 15 provides an indication of adoption performance. Numbers are small and adoption activity varies month by month, so the performance can appear to change significantly over the course of a year. There tends to be a push to get adoptions secured in the period between around now in any financial year and the end of the year. Adoption performance in Peterborough is good overall, as was noted by OfSTED in the recent inspection.

Staff Recruitment and Retention

4.58. Workforce stability has improved since last year; of the 83.0 FTE front line social worker posts, 75% are now filled by permanent staff, accounting for new starters beginning with the authority over the next few weeks. This compares with around 65% in October 2014.

4.59. Of the 10 front line team managers [three in First Response, four in Family Support and three in the Children in Care and Leaving Care teams], seven are permanent members of staff with two permanent appointments having recently been made. Looking back a year, four of these posts were vacant – all of those in First Response, and one in Family Support.

4.60. At head of service and assistant director level, the position is also much better than a year ago. We have one locum head of service covering the children in care service, otherwise

the remaining heads of service for family support, first response, quality assurance and fostering and adoption are all permanently filled. We also have a permanent assistant director in post. In October 2014, only the heads of service for fostering and adoption and children in care services were filled permanently. The then head of service for children in care is the current head of service for first response. The assistant director role was also covered by a locum member of staff.

4.61. Staff retention is helped by having in place good systems for training, development and support. The Principal Social Worker now chairs the Social Work Forum, and members are champions when it comes to putting new practice standards across the service. Team Managers have commenced a dedicated development programme that will build their management and leadership skills, ensuring that they feel valued, while helping them to support the continuing practice developments in their service areas.

Concluding Remarks: CSC Performance

4.62. Each of the heads of service within Children's Social Care have been allocated a specific performance area for which they are accountable.

4.63. This clear accountability framework represents a new approach to managing performance within the service, and is one that we will continue to review in order to monitor effectiveness.

4.64. Once an ICT system is in place that is able to produce performance information on a real time basis, managers will have the benefit of more up to date performance data. There are a number of stages to implementation, including an upgrade to Liquid Logic to bring the system up to the most recent version. This means live performance reporting is unlikely to be achieved prior to the end of the financial year.

THE HEALTHY CHILD PROGRAMME AND ASSOCIATED COMMISSIONING ACTIVITIES

4.65. Peterborough City Council is the lead commissioner for children's health services across Peterborough and Cambridgeshire. Much of child health is delivered by the Cambridge and Peterborough Foundation Trust [CPFT] across the two local authority areas, making it sensible for there to be a single lead local authority.

4.66. Commissioning responsibilities for Health Visiting transferred to local authorities from NHS England on 1st October 2015. At the same time, the Department of Health has announced a consultation for an in year reduction to the Public Health Grant. This grant funds a number of universal and targeted activities to promote long term improvements in health outcomes, as well as providing statutory funding for a number of services such as for the treatment of substance and alcohol misuse.

4.67. In the event that the reduction to the Public Health Grant does go ahead, the Health and Wellbeing Board will need to review current priorities.

4.68. The Care Quality Commission [CQC] published its inspection report of the Cambridgeshire and Peterborough Foundation Trust [CPFT] on 13th October 2015. The overall outcome was that the Trust is 'Good'. However the report identified areas for improvement in areas including waits for specialist Child and Adolescent Mental Health Services and capacity issues with Speech and Language Therapy for children and young people.

4.69. Action was already being taken prior to the CQC inspection to address waiting lists for specialist child and adolescent mental health services. The Clinical Commissioning Group had identified additional one off funding of £300,000 in the current year to address the waiting list, and £600,000 on-going funding to address the cause of the waiting list build up, which is a rise in demand for these services.

4.70. New national funding has also been made available to support mental health services for children and young people by the Department of Health, with £1M additional funding across Cambridge and Peterborough.

4.71. Cambridge and Peterborough Foundation Trust has an agreed target to reduce waiting times for assessment and treatment so that these are in line with national targets by April 2016. National targets are for nobody to wait longer than 6 weeks for assessment and up to a further 12 weeks for the commencement of any treatment that is needed.

4.72. As lead commissioner, Peterborough has been working with CPFT and the Clinical Commissioning Group to look again at how to improve pathways for children, young people and families in relation to specialist Child and Adolescent Mental Health [CAMH] services. An example is a new approach to supporting children and young people with possible neurodevelopmental disorders such as Autistic Spectrum Disorders. Where such a disorder is suspected, the first thing to be offered will be access to practical parenting support and advice. Where this approach confirms the possibility of a neurodevelopmental disorder, an onward referral for an assessment will follow.

4.73. This contrasts with the current position where a child may wait for a considerable period for an assessment that does not identify any disorder, but where often parents have not accessed other services because they are awaiting a diagnosis.

4.74. Additional funding has also been identified to consider the speech and language pathway in Peterborough and Cambridgeshire. Speech and language therapy, like CAMH services, is an area where the role of universal provision is central in promoting good outcomes and managing demand for children of all abilities and needs.

4.75. There is often pressure from schools and parents that a child needs more individual speech and language therapy. In fact children are more likely to benefit from early years and teaching staff who are skilled in encouraging language development and who can coach parents and carers to develop the same skills.

4.76. Most research also indicates that settings and schools that are able to promote the best speech and language development for pupils with additional support needs are also the ones that secure the best outcomes for language development for all pupils.

4.77. Finally, we are working with CPFT to re-establish the Strengths and Difficulty Questionnaires for children and young people in care. This is a measure of the emotional health and wellbeing of each individual child or young person, which should take place at least annually.

4.78. These were discontinued in Peterborough in 2013 because many young people and carers reported that they perceived little benefit from completing the questionnaire. A decision was made that emotional and mental health issues would be better picked up in the annual health assessment. However, the OfSTED inspection identified that this approach was not leading to a sufficiently developed understanding about the mental and emotional health needs of children in care.

4.79. The lesson learned from the earlier use of these questionnaires is to ensure that information gathered from them results in material change for children and young people. A process is therefore being put in place that will result in the Strength and Difficulty Questionnaire being completed prior to the annual health assessment. The individual findings will be discussed as part of the assessment itself. Where additional needs are identified, these will result in an onward referral to the appropriate service. General information about needs identified will be used to inform the commissioning of emotional and mental health services for children in care.

THE SAFEGUARDING CHILDREN BOARD AND SAFEGUARDING ADULT BOARD

4.80. The Care Act 2014 has introduced a number of changes in relation to the safeguarding of vulnerable adults.

4.81. One of these changes is to place Safeguarding Adult's Boards on a statutory basis, in line with Safeguarding Children's Boards. Within this context, it has made sense to explore how the work of the two boards can be brought closer together.

4.82. The Business unit which supports the work of the Peterborough Safeguarding Children Board and the Peterborough Adult Safeguarding Board have been reconfigured to form one unit. This will provide efficiency savings while ensuring consistency of approach across the safeguarding agenda. This new business unit has been working as unified team since mid-September 2015.

4.83. Since September, a multi-agency safeguarding training programme has been launched that covers both the children's and adults' workforces in Peterborough. This approach ensures consistency of information about safeguarding across the whole workforce and recognises that, for example, practitioners working with adults may encounter safeguarding issues affecting children in their work and vice versa.

4.84. The Quality and Effectiveness Groups that sit under the two boards have been merged to form one sub-group. This single group looks at quality of practice across both the children's and adult's workforce. There will be a single performance framework across the two boards which will include a dataset, quality assurance activity and feedback from service users. Audits are planned to take place across the two service areas, which will provide a holistic view of practice as this affects families. It has been agreed that the first "joint" audit will look at transitions between children and adult services – an issue that causes many parents and young people concern. This audit is planned to take place in early 2016.

4.85. The role of the child sexual exploitation officer has recently been extended to include vulnerable adults who are also at risk of or who are being sexually exploited. The Boards are working closely with a variety of Council services and the police to assess how this role can be utilised to maximum impact.

4.86. In addition to the above there is currently a joint piece of work between the Children's Safeguarding Board and Adult's Safeguarding Board which is looking at refreshing the documents that relate to the thresholds for services. It has been established that there needs to be a separate document which details the threshold for services for children's and adult services. However, it has also been agreed that there will be a set of joint principles that governs both documents and the work that they refer to. These principles will apply to issues such as consent. This approach will assist in providing consistency across the two service areas.

DEVELOPING A SINGLE APPROACH TO QUALITY ASSURANCE

4.87. Children's Social Care and Adult Social Care are now part of the same Directorate: People and Communities.

4.88. As noted above, the Care Act has also placed greater emphasis on adult safeguarding. Numbers of adults receiving services at any one time are much greater than the number of children who do so. This, combined with the way in which care is delivered to vulnerable adults and older people in particular, means that there is a greater potential for the need for more complex enquiries into adult safeguarding issues than in children's services.

4.89. At one end of the spectrum, a concern may be received about an individual vulnerable adult. The concern may be, for example, that their carer – a family member or friend – is mistreating them or exploiting them for financial gain. Such enquiries require extreme sensitivity and are properly led by a social worker allocated to the case.

4.90. However, where concern relates to the care provided to an adult resident of a care home, there is potential for these concerns to affect a number or all residents of that home. Enquiries of this nature introduce further complexities, where the needs and rights of the adults concerned to receive high quality care must also be balanced with the impact of any potential changes of care arrangements, taking into account the wishes and feelings of the adults concerned.

4.91. In most such circumstances, issues raised are best approached in a problem solving approach, and benefit from independent oversight. In this respect, there are parallels with the way that complex safeguarding investigations are undertaken within Children's Services, with independent oversight from the children's Local Authority Designated Officer.

4.92. This independent oversight is more likely to result in an outcome where the provider is supported to make changes in the care they provide in order to better meet the needs of the residents, addressing the issues while avoiding unnecessary disruption to the lives of the vulnerable residents.

4.93. It is proposed that responsibility for making enquiries about these more complex issues will sit within the new joint Quality Assurance Service, along with responsibility for undertaking audits to assess quality of practice in both Children's and Adult's Social Care and the chairing of child protection conferences about individual children at risk of significant harm.

4.94. It is proposed that this service will report through a Head of Service directly to the Service Director for Children and Safeguarding. This approach provides a degree of independence from direct operations, which lie with Assistant Directors for Children's Social Care and Adult Services respectively.

4.95. Funding is being made available from central Government to support the implementation of the Care Act. Developing a joint quality assurance unit in this way will enable practice in Children's and Adult services to evolve together, while creating more efficiency in terms of the overall costs of the structure.

4.96. A business case will be developed in November, and any current members of staff affected will be consulted in line with formal Council procedure.

5. KEY ISSUES

5.1. Key issues arising from the above include:

- Many performance indicators within Children's Social Care are interrelated and it is not always easy to specify what good performance within a single indicator is in isolation from others;
- Many areas of the service are showing improvement as the management and leadership arrangements are becoming established, however;
- Areas of performance where improvement continues to be required, such as the timeliness of visits to children on child protection plans, have been allocated to individual heads of service to improve accountability;
- Reductions in overall numbers of children and young people open to the service to levels consistent with long term activity rates will assist in improving performance;
- Development of ICT capacity to enable 'live' performance monitoring will help managers to improve performance further as well as providing an early indication of where the application of thresholds may have moved away from the standard;
- Prevention and Early Help services were identified as a strength in the recent OfSTED inspection and work to develop thresholds that emphasise the importance of early help prior to referral to children's social care in non-urgent situations will lead to better results for individual children and reduce the time spent screening contacts in Children's Social Care;
- Peterborough is the lead commissioner for Children's Health Services across Cambridgeshire and Peterborough, reflecting closer working relationships between the authorities;
- The recent Care Quality Commission inspection of the Cambridgeshire and Peterborough Foundation Trust identified that services provided were good overall;
- One area identified where improvement is needed is waiting lists for specialist mental health services for children and young people. The local Clinical Commissioning Group had responded to this need prior to the inspection, identifying additional resources to tackle the waiting list;
- A joint business unit now supports the work of the two statutory multi-agency safeguarding boards;
- This approach should help to bring consistency to the way that safeguarding issues affecting children and vulnerable adults are identified and responded to, and;
- Proposals are being developed to bring together the work of the quality assurance roles in Children's and Adults' services, which will support the establishment of common practice standards and ensure that the service can respond to complex safeguarding issues affecting numbers of vulnerable adults receiving care from the same care provider.

6. IMPLICATIONS

6.1. There are potential HR implications arising from the proposals to develop a single quality assurance service. In the event that this is the case, a full consultation process will take place in line with Council procedures.

7. CONSULTATION

7.1. Consultation has taken place with relevant senior officers within Children's Social Care and with the Performance Team.

7.2. In line with the agreement reached at Scrutiny in September 2015, there has been an opportunity for the Chair of Scrutiny and the Independent Co-opted Member, Mr Al Kingsley, to meet with the Service Director to look in detail at the performance information prior to the Scrutiny meeting on the 16th November 2015.

8. NEXT STEPS

8.1. The format and layout of this report hopefully reflects feedback from Members about the information that is needed in order to enable effective scrutiny of performance. This report will continue to evolve in response to feedback from the Committee.

9. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985:

9.1. Performance Report for September 2015, published by the Performance Team.

10. APPENDICES

10.1. Appendix 1: Service Director Children and Safeguarding Report.