Peterborough City Council

Inspection of services for children in need of help and protection, children looked after and care leavers

and

Review of the effectiveness of the Local Safeguarding Children Board[1]

[1] Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspection Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is good

An LSCB that is **good** coordinates the activity of statutory partners and monitors the effectiveness of local arrangements. Multi-agency training in the protection and care of children is effective and evaluated regularly for impact. The LSCB provides robust and rigorous evaluation and analysis of local performance that identifies areas for improvement and influences the planning and delivery of high-quality services.

Executive summary

The LSCB has played a key role in engaging partner agencies in the safeguarding agenda. It has monitored the work of agencies and provided both robust challenge and leadership in some important areas where services provided have not been good enough or have needed further development. It has been effective in coordinating responses to the considerable challenges presented by child sexual exploitation but although the LSCB monitors numbers of children at risk of child sexual exploitation, it has not consistently monitored the usage of risk assessment tools or the quality of assessments completed.

Although the analysis within the quarterly performance reports provided to the board draws out key themes from the data included and is particularly strong with regard to early help, it does not take advantage of the wealth of wider information available from sources such as feedback from children and their families or audits. This limits the board's ability to fully understand the detailed reasons for any areas of poor practice. The LSCB has a strong programme of audits that have led to some real improvements in practice such as improved attendance at core groups and more timely domestic abuse notifications from the police. The LSCB is also increasingly effective in engaging young people in scrutinising and improving practice. The involvement of young people in the child sexual exploitation audit is a particular example of good practice. The Youth MP is a member of the LSCB and good attention is paid to the voice of young people.

While a strong early help strategy offer is making a difference to families, the absence of a formal, written neglect strategy means that neglect is not given a sufficiently high profile across all partner agencies. The LSCB is aware of the need for this to be an area of focus and of the need to implement recommendations from its child in need task and finish group.

The LSCB is well led by the independent chair and supported by a tenacious business manager. It is appropriately structured with a range of effective sub-groups and meets its statutory responsibilities. Through his membership of the Achieving Outstanding Board, the successor body to the previous local authority improvement board, the chair of the LSCB has provided challenge on behalf of the LSCB. Partner agencies are well represented on the board and attendance is good. The LSCB has

good links with other strategic bodies such as the health and wellbeing board through which it is able to exert influence. The board's website is accessible, informative and engaging. The board has been active and successful in engaging with the full range of communities and faiths within the city.

Learning from serious case reviews is shared effectively. Progress by partner agencies in implementing recommendations is closely monitored through the use of an effective integrated serious case review action plan. Further work is required to ensure that there are systems in place to ensure that action is sustained. The range, quality and reach of training provided by the LSCB are good and there are well-developed arrangements to evaluate the quality of the training and its impact on learning and practice. Young people have helped to plan and deliver training.

However, despite LSCB training, not all professionals fully understand the operation of thresholds. The distinction between the level of need of children who could benefit from early help services and those who may be children in need is not sufficiently detailed within the current threshold document and the revised document is not yet complete.

Recommendations

145. Update the performance management framework and enhance quarterly performance reports to the board so that a full range of information, including learning from audits and feedback from children, is used to strengthen the LSCB's ability to monitor, challenge and hold to account all partners for their safeguarding practice.

146. Prioritise the revision of the threshold document so that it is clear about the distinction between children in need and those who could benefit from early help services and 'step up' and 'step down' thresholds are well understood by practitioners and managers in partner agencies.

147. Monitor the local authority's response to the findings of this inspection in relation to the quality of social work assessments, chronologies and plans, and provide appropriate feedback and challenge to support it in making the necessary improvements.

148. Implement the new child sexual exploitation risk assessment tool as soon as possible and monitor both its use and the quality of assessments completed to ensure that the level of children's risk is being accurately identified and that they are receiving the help they need.

149. Ensure that the issue of neglect is given a suitably high strategic and operational profile and that activity to tackle neglect is well-coordinated across all partner agencies. The LSCB should consider the need for a formal multi-agency neglect strategy.

150. Ensure that findings and recommendations arising from the child in need task and finish group are implemented and their impact monitored to help improve outcomes for this vulnerable group of children and young people.

Inspection findings

151. The LSCB fulfils its statutory responsibilities as set out in the Children Act 2004 and the Local Safeguarding Children Board Regulations 2006. It monitors and evaluates the effectiveness of what is done by the local authority and its board partners individually and collectively to safeguard and promote the welfare of children and advises them on ways to improve. The board has provided strong challenge and leadership to partner agencies, leading to improvements in a number of areas, including the timeliness of medicals for looked after children and police notification of incidents of domestic abuse, the local authority's commissioning and recording of return home interviews for children who have been missing from home or care and agencies attendance at core groups.

152. The independent chair of the LSCB has been in post since April 2013 and is well respected by partner agencies for his energy, commitment and challenge. All agencies describe how he has skilfully reorganised the LSCB and ensured that a wider range of partners are involved in its work. The independent chair has regular meetings with the Director of Children's Services and the Chief Executive of the council and has no hesitation in offering challenge. The new business manager is also highly thought of for her knowledge and skills and for her role in heightening awareness of safeguarding in Peterborough. Partner agencies are well represented on the board and attendance is good. The LSCB website has been redesigned and is accessible, informative and engaging.

153. Through his membership of the Safer Peterborough Partnership, the Health and Wellbeing Board and the Joint Children and Families Commissioning Board, the independent chair ensures that there are good links between these bodies and the LSCB. As a member of the Achieving Outstanding Board, which replaced the former Improvement Board, the independent chair has used case audit evidence to challenge some deficits in frontline social work practice. This has led, for instance, to significant improvements in the multi-agency response to vulnerable children through better coordinated early help work and the development of the high quality multi-agency safeguarding hub, resulting in children having their needs met earlier and more thoroughly. The chair of the LSCB also met with the chief executive of the Cambridge and Peterborough Foundation Trust to discuss waiting times for access to CAMHS. Additional funding for CAMHS has since been agreed.

154. The LSCB multi-agency dataset includes performance management information from a range of agencies including the local authority, health, police and schools. It contains a strong section on the effectiveness of early help but information in relation to child sexual exploitation is limited and there is no information about children missing from home or care. The board are aware of

these gaps and are active and persistent in challenging the local authority and partners to ensure that reliable data are made available for these important areas of work. The multi-agency dataset is used to provide a quarterly performance report to the board. While this does assist the board in challenging and holding partners to account for their performance, the analysis within this document is based on the quantitative data provided for the dataset and does not take advantage of the range of qualitative information available, such as feedback from children and young people or information from audits. This means that the board is not provided with a report that provides as full and as informed a picture of performance and outcomes for children as they could be. This gap is also present in the LSCB's performance management framework. The document lucidly details the role of audits, performance data, serious case reviews and other key elements in monitoring the safeguarding work of agencies but contains no reference to feedback from children or their families and does not explain how these different elements can be brought together to more effectively understand the reasons for areas of poor performance and the possible solutions to performance deficits. This is a missed opportunity since this bringing together of different aspects of performance information does happen in practice in some discussions at the board's quality and effectiveness group and the LSCB is increasingly effectively engaging with children and young people to inform its work. The LSCB's engagement with young people as part of its child sexual exploitation audit is a particular example of good practice.

155. The LSCB has had a pivotal role in coordinating work across the partnership to disrupt the activity of, and prosecute, those responsible for child sexual exploitation. In particular, the LSCB made a significant contribution to the success of Operation Erle. Partners worked closely together to identify and win the trust of young people who were vulnerable to child sexual exploitation. This victim-led approach resulted in offenders being identified and a series of high-profile convictions, which raised awareness of child sexual exploitation considerably and has helped to make Peterborough a safer place for children and young people.

156. Having identified through its audit activity that the high turnover of staff in children's social care was impacting on the ability of social workers to consistently evaluate and record their work with children and young people who are potentially at risk of child sexual exploitation, the LSCB made the decision to fund a part-time child sexual exploitation coordinator. This post sits within the Peterborough Safeguarding Children Board business unit to provide a dedicated child sexual exploitation lead but also spends time within the MASH to add capacity and enhance the coordination of agencies' work in this area. It is still too early to evaluate the effectiveness of this role.

157. The LSCB has also been effective in promoting awareness of child sexual exploitation among young people and across the city. Since 2013, over 3,000 young people have seen a production of Chelsea's Choice, following on from which safer school officers have been delivering the 'exploited' training programme in secondary schools to further raise awareness of child sexual

exploitation. All 480 'approved drivers', including taxi drivers, bus drivers and volunteers, licenced to transport children in the city have completed mandatory training as a pre-condition of them continuing to be licensed. Local hotels have been involved in a 'See Something, Say Something' campaign and over 120 professionals and members of voluntary organisations attended a half-day conference on child sexual exploitation organised by the PCSB.

158. The LSCB's priorities are appropriately wide-ranging and demonstrate a clear focus on improving safeguarding across the city. The LSCB has contributed effectively to the improved coordination of services in response to domestic abuse. The business plan is clear, detailed and regularly updated. However, this document does not do justice to the LSCB's tenacity in striving for better outcomes for children, for example in challenging the police to improve the timeliness of domestic abuse notifications and challenging health to improve the timeliness of health assessments for looked after children. It also does not sufficiently reflect the LSCB's achievement in engaging with young people as part of the child sexual exploitation audit to help shape future practice.

159. The LSCB is purposeful and business-like in its approach. A good range of sub-groups is involved in driving the LSCB's work programme around, for example, quality and effectiveness, child sexual exploitation, training and learning, e-safety and serious case reviews. Two sub-groups focus specifically on engaging and involving schools and frontline health professionals in improving safeguarding practice. The Child Death Overview Panel (CDOP) is one of four sub-groups shared with the neighbouring Cambridgeshire LSCB in a way that gives the board access to a broader range of skills, knowledge and expertise than would otherwise be the case.

160. The CDOP has been effective in analysing local information on child deaths and in identifying patterns and trends. It has developed and rolled out two good awareness-raising programmes focused on safety in and near open water and on the risks associated with adults co-sleeping with young babies. The CDOP has not identified any preventable deaths and has not felt it necessary to refer any cases to the LSCB because of concerns about professional practice.

161. The LSCB undertakes, at two-yearly intervals, a section 11 audit of the partners' effectiveness in carrying out their safeguarding responsibilities. The results of the last section 11 audit, which all of the LSCB's statutory and non-statutory partners completed, were presented to the LSCB in September 2013. The audit found that 83% of indicators were fully met across the partner agencies. Last year 60% of primary and 55% secondary schools participated in a section 175 safeguarding review. The chair of the LSCB has written to those schools that did not complete a return to encourage them to do so in future. The LSCB also has plans to extend the review to colleges.

162. The LSCB has adopted a very robust approach to serious case reviews; it has issued comprehensive guidance and an independent management review resource pack. Five serious case reviews have been carried out in the last year,

a significant commitment for a small unitary authority. Only one of those cases involved the death of a child. In the four other cases, the LSCB opted to use the serious case review process as part of its commitment to increase confidence in the partnership by adopting a transparent approach to identifying and learning from any possible deficiencies in practice or partnership working.

163. The learning from these reviews has been effectively shared and used to inform improvements. Findings of local and national serious case reviews are disseminated well through the use of briefings across the children's workforce. Progress by partner agencies in implementing recommendations is closely monitored through the use of an effective integrated serious case review action plan. Prompted by learning from a serious case review about a young eastern European child and working alongside Norfolk and Cambridgeshire LSCBs, the board has also been successful in securing a grant from the government's innovations fund and a project has been established to identify ways of communicating and engaging better with children and families from eastern European communities.

164. The LSCB uses multi-agency case audits to increase its understanding of the quality of frontline safeguarding practice and identify areas for improvement. For example, it commissioned an external audit of early help services which included observation of multi-agency support groups (MASGs), team around the child meetings and a case file audit of 15 cases. Drawing on this work, the board's annual report sets out a detailed analysis of partner engagement in early help assessment and intervention and their impact for children and families. This has enabled the LSCB to identify a number of priorities and put an action plan in place to further strengthen practice. A follow-up audit is planned for later this year to evaluate progress.

165. Last year, as part of its programme of themed multi-agency audits, the LSCB reviewed the multi-agency response to domestic abuse, resulting in clear recommendations and action plans. The domestic abuse audit found that, while there was evidence of good multi-agency working in the majority of cases, in a small number of cases, where there were disagreements about the need for further action, concerns were not escalated appropriately. Partner agencies are now required to send copies of all escalations to the board for quarterly monitoring. Notifications of domestic abuse incidents are now routinely shared across agencies and the pooling of resources has led to the employment of an advocate, based in the MASH, to better support victims of domestic abuse.

166. Despite a business plan commitment to ensure that children are fully protected from neglect, neglect has not been given a sufficiently high priority to date. The LSCB does not have a neglect strategy and has not focused on the particular importance of social workers constructing and using chronologies to help identify patterns of neglect that may otherwise go unidentified. An audit is planned later in 2015–16 to strengthen strategic and operational responses to an issue that LSCB members recognise is having a significant impact on many vulnerable children and families in Peterborough. The LSCB is aware of the

importance of a neglect strategy and of this audit but in their absence the board cannot be fully assured that partners' work in this area is well coordinated and effective.

167. While looked after children have not featured prominently in the LSCB's annual report, there is an action within the board's business plan ensuring the PSCB links with the corporate parenting panel and the independent reviewing service. This helps to keep a focus on looked after children and recent board minutes demonstrate greater attention paid to the needs of these young people. The LSCB has reviewed the way in which information about looked after children placed in Peterborough by other local authorities is shared with the police. It has also challenged performance on initial health assessments for looked after children.

168. Recent activity has also focused on raising awareness of female genital mutilation (FGM). In partnership with Cambridgeshire LSCB, the PSCB has produced an FGM resource pack which has been shared with agencies across Peterborough. The production of this resource pack, which contains helpful practice guidance, information on training and a suite of leaflets prepared with the involvement of a group of young people, is a significant and positive achievement.

169. Training provided by the LSCB is of a high standard. Over the last 12 months more than 1,000 people involved in working with children and young people have attended a range of safeguarding courses. This has included courses designed specifically for GPs. Regular follow-up contact is used to identify how practice has improved as a result of the training provided. For example, feedback from schools and health workers shows that many of them now feel better able to recognise safeguarding issues and are more confident about making referrals to children's social care. Inspectors also heard very positive feedback from foster carers and other professionals about the quality of the training provided. The LSCB has involved young people in planning and delivering training.

170. Inspectors found evidence that, despite the training provided through the LSCB, not all professionals fully understand the operation of thresholds. The distinction between the level of need of children who could benefit from early help services and those who may be children in need is not sufficiently detailed within the current threshold document and the revised document is not yet complete. Board members are currently involved in revising the multi-agency threshold document on access to children's social care services. It is a strength that the current document contains an escalation policy for when there are disagreements between professionals about levels of need but this should be in addition to a document that is sufficiently clear throughout. In particular, in a small number of cases seen as part of the local authority inspection, decisions to 'step down' from social care to early help services had been taken prematurely.

171. The LSCB Annual Report 2013–14, published in September 2014, is a comprehensive document. It lists key achievements, highlights lessons learnt and identifies a clear set of priorities. However, while the LSCB and the independent chair have been influential in challenging partners to improve practice and services, the report itself lacks a sense of what it is like to be a child in Peterborough. Although it includes some performance data, it is not sufficiently analytical, particularly with regard to the quality of frontline child protection services delivered by the local authority. The board has already recognised these limitations and is confident that this year's report, due to be published in June 2015, will cover these areas more robustly.

172. A range of good initiatives have been used to involve children and young people in safeguarding in Peterborough. The LSCB received 515 replies to a survey sent out to pupils in Peterborough secondary schools. 72% of children and young people reported that if they had concerns about child sexual exploitation, they would be most likely to speak to a teacher to seek help or advice. In order to ensure that pupils receive the best possible support, the LSCB responded quickly and positively by working with schools to ensure that each secondary school has its own child sexual exploitation coordinator. The LSCB's child sexual exploitation coordinator holds termly focus meetings for the leads to provide training and to share good practice. The LSCB has acted on a request from young people by including 'QR' codes on posters and leaflets which allow young people to scan and read the information later and provide a link to the LSCB website. Local young people have also been involved in designing leaflets on child sexual exploitation. The LSCB is currently training a group of pupils to act as 'safeguarding internet safety ambassadors' and a young person has now been invited to join the board.

173. The LSCB is clearly aware of the need to engage with all of the faith communities within the city. It has worked closely with the Muslim council of Peterborough to publish a booklet, 'Safeguarding children and young people in mosques and madrasahs in Peterborough', coordinating the delivery of safeguarding training in to all mosques and a number of madrasahs.

Information about this inspection

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition, the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people who it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

Ofsted produces this report of the inspection of local authority functions and the review of the Local Safeguarding Children Board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

The inspection team consisted of eight of Her Majesty's Inspectors (HMI) from Ofsted.

The inspection team

Lead inspector:	Nigel Parkes
Deputy lead inspector:	Susan Myers
Team inspectors:	Derrick Baughan, Rob Hackeson, Tracey Metcalfe, Neil Penswick, Tina Shepherd, Ty Yousaf and Dominic Stevens
Quality assurance manager:	John Mitchell

Any complaints about the inspection or the report should be made following the procedures set out in the guidance 'Raising concerns and making complaints about Ofsted', which is available from Ofsted's website: www.ofsted.gov.uk. If you would like Ofsted to send you a copy of the guidance, please telephone 0300123 4234, or email enquiries@ofsted.gov.uk.

The Office for Standards in Education, Children's Services and Skills (Ofsted) regulates and inspects to achieve excellence in the care of children and young people, and in education and skills for learners of all ages. It regulates and inspects childcare and children's social care, and inspects the Children and Family Court Advisory and Support Service (Cafcass), schools, colleges, initial teacher training, further education and skills, adult and community learning, and education and training in prisons and other secure establishments. It assesses council children's services, and inspects services for looked after children, safeguarding and child protection.

If you would like a copy of this document in a different format, such as large print or Braille, please telephone 0300 123 1231, or email enquiries@ofsted.gov.uk.

This publication is available at www.gov.uk/government/organisations/ofsted.

Interested in our work? You can subscribe to our monthly newsletter for more information and updates: http://eepurl.com/iTrDn.

T: 0300 123 1231
Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
W: www.gov.uk/government/organisations/ofsted

W: www.ofsted.gov.uk

This page is intentionally left blank