The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement

Executive summary

The board has very good understanding of its strengths and weaknesses. SLSCB meets its statutory functions. It benefits from appropriate multi-agency membership, very good attendance and strong commitment, including from three lay members who bring independent challenge to the board's work. However, the board has lacked thoroughness in aspects of challenge and analyses of some key areas of its purpose. It does not yet have clear mechanisms for analysing, evaluating and collating how partner agencies are ensuring the effectiveness of their practice in respect of some key safeguarding practice. Performance information has been too focused on data and not on the underlying explanations of why performance is good or poor.

Insufficient action has been taken to ensure that thresholds are understood across partner agencies. Furthermore, the 2016–17 joint Stockton-on-Tees and Hartlepool training programme has been introduced without a full needs analysis, despite under-participation on some courses in 2015–16.

Although the board has commissioned work on the influence and 'voice of the child', it has yet to ensure that this is embedded in the work of the board and across all partner agencies.

A key strength of SLSCB is the work of the sub-groups, especially those working across other Teesside local safeguarding children boards, including the vulnerable, exploited, missing and trafficked group (VEMT), which adds strength and challenge to safeguarding children, the shared procedures sub-group and the child death overview panel (CDOP).

The board has been instrumental in shaping services for children and young people in Stockton-on-Tees, including those for domestic abuse and promoting the safety of children in public settings, and has been influential in the introduction of the multi-agency children's hub.

The annual report 2014–15 lacks rigour. While it includes a great deal of information, it is too lengthy, and does not include sufficient assessment and analysis of performance and effectiveness.

Recommendations

110. Ensure that quality assurance and performance management processes provide clear analyses, so that the SLSCB has a clear understanding of the effectiveness of partner agencies.

111. Ensure that the joint Hartlepool and Stockton-on-Tees threshold document is effectively used and understood by partner agencies.

112. Ensure that the views of children and young people help to influence the work of the board and the safeguarding practice of all partner agencies.

113. Undertake an analysis and evaluation of need to inform the Stockton-on-Tees and Hartlepool 2017–18 joint training programme.

114. Ensure that the annual report for 2015–16 is succinct, and includes a clear analysis of performance and the effectiveness of partner agencies in undertaking their safeguarding functions.

Inspection findings – the Local Safeguarding Children Board

115. The board is constituted in line with statutory guidance. Members of the board are committed to promoting the multi-agency shared priorities. Attendance of board members at the monthly meetings is consistent, and this helps to ensure that vital issues are disseminated to partner agencies. The board has three lay members, who provide an independent perspective and challenge. There is a good range of sub-groups to consider and progress strategic areas of safeguarding practice. The sub-groups are well established and attended, and report regularly to the full board on performance, the VEMT, learning and improvement, training, licensing and procedures.

116. There are strong governance arrangements across children's services and key partnerships boards, including the HWB, children and young people's partnership board and Safer Stockton group. These ensure that the priorities of the SLSCB link to those of these important boards and the overarching priorities of the JSNA. However, the independent chair of the board has identified that the SLSCB business plan and priorities could be better aligned to the JSNA and HWB priorities.

117. The independent chair of SLSCB was appointed in April 2016. He is also the independent chair of a neighbouring LSCB and has a very good understanding of his role. The independent chair demonstrates openness and honesty in identifying positive practice of the board, areas for improvement and, importantly, how areas for improvement will be addressed. He is also keen to ensure that the work of the SLSCB is determined by all the representative agencies. Prior to his appointment, SLSCB already had well-established working arrangements. These have been developed further, and the momentum of the board has been intensified by new membership and changes to how meetings are organised,

which are enhancing the quality of discussions and challenge. The board is well-resourced with an appropriate budget, and benefits from a full-time, experienced, board manager who has good administrative support.

118. In 2014–15, only four multi-agency audits were undertaken. Consequently, the board did not have a comprehensive overview of the effectiveness of partners in important areas of safeguarding practice. The board recognises this weakness and, to compensate, in 2015–16 a range of thematic reviews were commissioned and reported to the board. These focused on the quality of frontline practice, including child protection plans, casework, initial child protection conference attendance, section 47 enquiries and conference decision-making. These findings, along with learning from serious case reviews and serious incidents, have resulted in an agreed programme of multi-agency auditing for 2016–17. The programme will focus on issues of domestic violence, alcohol and substance misuse, and adult mental health, as these remain significant drivers of the workload in early help and social care, and for all agencies.

119. Other routine reports to the board are provided in respect of private fostering, the designated officer, youth offending, children missing education, children home educated, the work of independent reviewing officers, children living out of the local authority area, children looked after (including care leavers), children missing and the work of the VEMT. The board has a rich source of information from these reports, and there is evidence of board members challenging each other's practice and taking forward the findings to their individual agencies. However, the inspection findings and performance data that were seen indicate that further work is needed to ensure improvements, especially in relation to the quality of care plans, attendance and contributions to reviews, and consistent application of thresholds guidance. Importantly, there is no clear mechanism for the board to monitor and collate information on the effectiveness of all partners in improving these key areas of practice. (Recommendation)

120. The joint Hartlepool and Stockton-on-Tees threshold document 'Providing the right support to meet a child's needs in Hartlepool and Stockton', launched in February 2016, preceded the introduction of the multi-agency children's hub in June 2016. It was anticipated that the new threshold guidance would result in improved application of thresholds by partners. However, too little emphasis has been given to the launch to ensure that all partner agencies have an appropriate understanding of the thresholds when making referrals to children's social care. There is no mechanism for the board to assess how effective agencies have been in the application of the new guidance. (Recommendation)

121. The current performance dataset consists mainly of children's social care measures, with some information from health and housing partners, and does not include any data in relation to other partner agencies. The dataset includes some benchmarking criteria, but there is no commentary to interpret the data. The limitations of this performance information are acknowledged, and the sub-group recognises a need to include commentary about the data information to gain a clear understanding of the issues underlying

performance. This has the potential to facilitate a more coordinated and effective approach by agencies, for example in understanding thresholds and consequently ensuring that referrals are made appropriately. This approach is intended to link closely to the new performance framework which is being introduced across Teesside.

122. The four Teesside local safeguarding children boards (Hartlepool, Stockton-on-Tees, Middlesbrough, and Redcar and Cleveland) have jointly secured funding from the Department for Education to design and implement a single multi-agency performance management framework and dataset. The ambition is to strengthen performance monitoring and promote better outcomes for children and young people. This is through improved monitoring and accountability of partners to the boards, improved decision-making and prioritisation, efficiency savings and consistency in the type of information collected. However, this framework is new and it is too soon to see any effect.

123. Effective arrangements are in place through the CDOP, which operates across the four Teesside local authorities. The Teesside approach ensures rationalisation of attendance and consistent feedback to individual agencies. In 2015–16, all reviews were undertaken within timescales. The CDOP panel includes a lay representative, which enhances challenge. The panel also benefits from attendance by three paediatric consultants. In 2015–16, only three of 12 child deaths in Stockton-on-Tees were unexpected. There are no specific themes arising from a review of recent children's cases, but the panel is proactive in taking forward learning and in challenging agencies. In 2015–16, this has resulted in important changes to regional services and practice, including improved communication with the coroner, policy changes in respect of instances of retention of placenta and coordinated work in respect of juvenile Huntingdon's disease. CDOP has also secured funding and reintroduced the rapid response team, which had been suspended in 2015.

124. The overall analysis from the most recent section 11 audits demonstrates that Stockton-on-Tees' partner agencies have a high commitment and application to their responsibilities, outlined in 'Working together to safeguard children 2015'. The standards are being met, in the main, and where agencies have identified that there is room for improvement, the deficiencies are included in their action plans. The rigour of section 11 audits has been enhanced by the establishment of face-to-face peer challenge of audit findings to ensure consistency and fairness in auditing.

125. The SLSCB learning and improvement framework defines and provides the basis for the work of the learning and improvement sub-group. This includes the processes for undertaking serious case reviews (SCRs) and learning reviews of significant incidents. There have been two SCRs published in the past two years, and a further two children's cases are currently being considered to ascertain whether they meet the criteria for a SCR. Learning from SCRs and serious incidents is cascaded effectively through specific training and briefings. Briefings are sent out to staff, and learning events are held where participants are asked to identify the key learning points for their

practice. Training course content is reviewed and changes are made to procedures to reflect learning. Learning from SCRs and reviews has resulted in better awareness and understanding, as well as changes to practice and procedures such as 'not brought to appointments', disguised compliance, professional challenge and chronic neglect. The majority of social workers seen by inspectors had a good understanding of the most recently published serious case reviews and awareness of the role of the SLSCB.

126. The procedures sub-group is a Teesside group. It produces and updates procedures, and maintains and updates the SLSCB website. The Teesside approach is good at ensuring consistency of practice, especially where partner agencies operate across the different authorities. A task and finish group reviewed the requirements from 'Working together to safeguard children 2015' and has ensured that all procedures are up to date. A further area of good practice is the expectation that every procedure brought to the board for consideration must include a 'voice of the child' impact assessment. Policies that have recently been updated include those on allegations management, dual process (child protection and children looked after), female genital mutilation, information sharing, complaints and seeking information from the police. Consideration for changes to procedures come from national guidance and legislation, as well as learning from SCRs, incidents and local issues.

127. The Teesside strategic VEMT sub-group is successful in providing a strong, strategic Teesside partnership to bring together key agencies and organisations to ensure a focus on the most vulnerable children and young people in Stockton-on-Tees. The close cross-boundary working with neighbouring authorities ensures that information, intelligence, identification, disruption and prevention activities are coordinated well, adding value and strength to the safeguarding capacity of agencies in the borough. Each of the four Tees boroughs has a sub-group which sits beneath the VEMT, working to the overarching Teesside strategy. Each sub-group has an individual action plan working to 'the four P's': prevent, pursue, protect and prosecute.

128. The independent chair acknowledges that further work is required to ensure that the 'voice of the child' is embedded throughout the SLSCB and within partner agencies. A recently commissioned consultation of children and young people has resulted in some very positive work within children's services and, consequently, the SLSCB has prioritised the need for further work to embed an approach to the 'voice of the child' in its work. This is through a framework which includes expectations for all partner agencies at strategic, operational and individual levels. As part of this work, the independent chair is keen to involve the Stockton-on-Tees 'Young Inspectors' in the work of the board. This is to improve communication and to ensure that children's and young people's views inform partner agencies' practice. (Recommendation)

129. The SLSCB's influence is clearly seen in the commissioning of services, and the development of policies and procedures to safeguard children. The board has been involved in the introduction of Operation 'Encompass',

providing early reporting by the police to schools and colleges on any domestic abuse incidents that may have an impact on a child and enabling staff to provide support where needed. The board has also been instrumental in developing 'A safer place for children' guidance, promoting the safety of children in public settings. In addition, the board has been influential in developing the social work model of risk assessment being rolled out across children's services and in early help settings. This is to assess and respond more effectively to cases of neglect. These areas of practice are already reported by partners as having an impact and leading to enhanced outcomes for children. Most significantly, the board has been pivotal in the introduction of the Stockton-on-Tees and Hartlepool children's hub in June 2016.

130. The Hartlepool and Stockton-on-Tees Local Safeguarding Children Board's training programme for 2016–17 aims to improve communication and information sharing between professionals, including a common understanding of key terms, definitions and thresholds for action. The programme offers a wide range of courses, including online training. The impact of training is measured by distributing evaluation forms to all delegates at the completion of the training. A subsequent evaluation questionnaire is sent out three months later to gather information on the impact of the knowledge acquired. The evaluation concludes that training in 2015–16 has had a positive impact on delegates' knowledge and confidence in dealing with safeguarding matters. However, there has been insufficient analysis of why the take-up of training has been low in some agencies and why there has been a 25% under-participation on some training courses. Consequently, the SLSCB cannot be assured that the current training programme is based upon an accurate needs analysis. (Recommendation)

131. The annual report 2014–15 includes a great amount of detail on the actions and work programme of the board during that period. However, the report is lengthy and lacks a clear analysis of the effectiveness of the board and partners in fulfilling their responsibilities to safeguard and promote the welfare of children in the local area, and in relation to the board's work. (Recommendation)

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.

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