The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement
The arrangements in place to evaluate the effectiveness of what is done by the authority and board partners to safeguard and promote the welfare of children require improvement.

Summary of findings

The LSCB requires improvement because:

Scrutiny, awareness and challenge

- A review of the Board has contributed to a better understanding of roles and responsibilities of individual members to ensure that safeguarding is given priority in Cumbria. As a result, significant improvements in how the Board is organised and holds agencies to account are in place.
- The partnership has a shared understanding and ownership of early help; thresholds have been reviewed and re-launched, but are not yet consistently understood or applied by all agencies.
- Step down arrangements between the local authority and early help services are not consistently established across the partnership, which leaves some children's needs unmet.
- Arrangements for the Board to monitor the number of children subject to an early help assessment are in place, but do not include evaluation of the outcomes for children that receive this support.
- The Board does not have sufficient strategic oversight, influence or challenge of the partnership arrangements concerned with domestic abuse.
- The Board is not providing challenge to the lack of urgency afforded by key partner agencies to respond to child sexual exploitation.
- The services for looked after children and the welfare of looked after children have not received sufficient attention from the Board.
- Arrangements to consider serious case reviews have been appropriately refreshed by the LSCB Chair, with improved decision-making processes now in place.

Training and practice development

- The training delivered to staff by the Board does not fully reflect the its current priorities. It is not evaluated to measure its long-term impact on practice and on outcomes for children.

Pre-publication

What does the LSCB need to improve?

Areas for improvement

Scrutiny, awareness and challenge

174.

175. Ensure that clear governance arrangements are in place so that the LSCB can evaluate the effectiveness of services provided to children who live in households where domestic abuse occurs.

176. Deliver the Child Sexual Exploitation Action Plan as developed from the LSCB self-assessment of child sexual exploitation. Develop robust measures to improve the Board's oversight of children and young people who go missing and who are vulnerable to child sexual exploitation.

177. Evaluate the outcomes for those children who receive early help services, including those who experience step-down arrangements when child protection or child in need plans end.

178. Monitor the effectiveness of all partners in promoting the welfare of looked after children.

179. Ensure that the annual report contains a rigorous and transparent assessment of the performance and effectiveness of local services, identifies areas of weakness and the causes of those weaknesses, and evaluates and where necessary challenges the action being taken.

Training and practice development

180. Develop a range of training opportunities which reflect the Board's current priorities, including children who are missing and vulnerable to child sexual exploitation, domestic abuse and early help practice. Evaluate the effectiveness of this training, including through feedback and audit activity.

181. Monitor and evaluate the consistent use of local multi-agency procedures by all agencies, including the application of thresholds.

Pre-publication

Inspection judgement about the LSCB

182. The independent Chair has been in post since April 2014 and is clear about the core functions of the Board and its statutory responsibilities. She has improved the functioning of the Board so that members' responsibilities and accountability are clearer. The membership of the Board was robustly reviewed by the Chair and effective changes were made. Although the membership has reduced, the current Board has representation from all statutory partners. All relevant agencies are represented by officers of appropriate seniority and attendance is good. The Chair has conducted individual appraisal and development sessions with Board members. As a result, the clarity for individuals about their role and contribution to the Board has improved.

183. Governance arrangements and relationships between the different strategic boards, including the children's trust board, the Adult Safeguarding Board, the Safer Cumbria Partnership (SCP) and the Health and Wellbeing Board, are clearly set out in a jointly agreed memorandum of understanding. The LSCB Chair also has regular, separate meetings with the local authority's Chief Executive, the Director of Children's Services and the Chair of the Adults Safeguarding Board. The local authority has provided additional funding to the LSCB to contract a vice chair to provide extra capacity to the leadership of the LSCB. This has increased the effectiveness and visibility of the LSCB and the confidence of the partnership. LSCB members sit on each of the other boards, and there is a standing agenda item for every meeting of the respective boards where all members are updated about relevant issues from other boards, and have an opportunity to raise items of mutual concern or interest or to challenge each other. The different boards are therefore aware of and able to support each other's work.

184. The Board has a constructive relationship with the Safeguarding Improvement Board. The chair of the Safeguarding Improvement Board confirmed their confidence in the LSCB Chair and increasing confidence in the partnership to effectively monitor and evaluate services to children. The Board has a range of sub-groups, including one for missing children and child sexual exploitation. Sub-group chairs represent a comprehensive range of partner agencies. Chairs and sub-group membership have the expertise and influence to ensure that the decisions and agreed priorities of the Board are progressed. The statutory and regulatory responsibilities of the Board are suitably integrated into sub-group arrangements.

185. The business group includes the chairs of all of the Board's sub-groups and is chaired by the independent LSCB Chair and meets before each main LSCB meeting. It is becoming an effective mechanism for ensuring that all of the sub-groups are regularly held to account for progress against agreed plans.

Pre-publication

186. The Board does not yet provide sufficient challenge or urgency in its oversight of arrangements for missing children and those vulnerable to child sexual exploitation. There is delay in obtaining the offender profile analysis from the police, which is overdue. The Board has failed to put local performance indicators in place to evaluate the effectiveness of the sexual exploitation strategy. Specific multi-agency training is planned but will not be available to staff until September 2015. Some examples of progress can be seen. For example, information on the prevalence of child sexual exploitation is available; a child sexual exploitation assessment tool has been developed; there are now designated child sexual exploitation 'champions' in social work teams, who are soon to be trained; there has been significant awareness-raising activity in schools including an event delivered to 7,000 young people; and since January 2015 there are arrangements in place for return interviews when children go missing. Child sexual exploitation is identified as a priority for the Board for the coming year and there is evidence of recent improvement. However, this is too little progress and the Board has not given this issue the urgency it requires.

187. Domestic abuse is a major area where the Board's strategic involvement and detailed knowledge are too recent and underdeveloped. Governance arrangements within the partnership mean that domestic abuse is the responsibility of the Safer Cumbria Partnership (SCP). Although the work of the SCP is reported to the LSCB, this provides insufficient direct evaluation of an issue which has a major impact on the safety and welfare of children in the area. This means that the LSCB's knowledge about the prevalence, nature and effects of domestic abuse is too limited to allow the Board to satisfy itself that partners are working effectively to safeguard children from the effects of abuse, and developing services to meet their needs. This is an identified priority for the LSCB business plan in 2015–16.

188. The Board's scrutiny and challenge to the effectiveness of child and adolescent mental health services has been on-going for a number of years as this has been a significant issue for the partnership for some time. Serious care reviews have repeatedly found a poor response to meeting children's needs by CAMHS. However, recent collaborative partnership working has seen the development of the HeadStart initiative to improve the emotional wellbeing of young people. A range of services has been commissioned and will be available from April 2015.

189. The Board has had limited awareness of the welfare of looked after children. This is an area of concern, but has not been a priority for the Board until very recently. The Board is not yet knowledgeable enough about the experiences of looked after children and young people in Cumbria to challenge partners about standards of practice and the welfare of this group of children.

Pre-publication

190. The Board is increasingly offering timely and robust challenge to all partners. Its challenge log records constructive challenge made to partners. Progress in respect of these challenges is managed through the business group. This is an effective system and partners report that the Board has experienced a significant, albeit recent, culture change which allows such challenges to be used as opportunities to develop and drive collaborative solutions. For example, the LSCB was appropriately provided with outcomes from the local authority-commissioned independent audit of children subject to child protection plans. The audit and quality assurance exercise concluded that thresholds had not been applied consistently and too many children were inappropriately subject to child protection plans. Partners were consulted about the review of these cases and, as a result, the numbers decreased rapidly. The Board and the Chair exercised appropriate and detailed oversight of this process. This included the Chair re-auditing cases to satisfy the Board that the local authority's own auditing and review of the cases had been safe and robust.

191. Partnership working has rightly prioritised the development of a safeguarding hub in recognition of past failures of triage arrangements to respond to contacts and referrals. A multi-agency programme board reports to the Safeguarding Improvement Board and the LSCB and has overseen the introduction of a safeguarding hub within six months. The hub has been subject to detailed monitoring, including external peer review, to support its development. The LSCB is the strategic driver of this work and has been instrumental in ensuring that significant and rapid improvements have been made.

192. The LSCB has revised, agreed and re-launched the local threshold document which is accessible and fit for purpose. This gives clear guidance on partners' responsibilities for helping families early when problems first emerge. The LSCB is monitoring the application of the threshold through its evaluation of the safeguarding hub, and recognises that thresholds are not understood consistently across the partnership. The LSCB actively monitors the prevalence and quality of early help assessments through audits and an external peer review. However, practice once the early help assessment is completed is not evaluated by the Board. It has not paid sufficient attention to the impact on outcomes that early help is having for children and families. In particular, the Board's awareness of the effectiveness of step-down arrangements between the local authority and early help services is limited and requires further work.

Pre-publication

193. Board members are responsible for ensuring that information and involvement in the Board are shared throughout the county. The education sub-group now has a primary school head teacher as chair and a secondary head teacher as vice chair, both of whom also have a specific responsibility to ensure that the Board's decisions are shared with the locality and sector bodies for education within the authority. They are also responsible for ensuring that Section 175 audits are completed to an acceptable standard. Similarly, the health group is chaired by a general practitioner who links with the six locality groups for general practitioners in the county. These changes represent an improvement on the previous organisation, and provide a framework for addressing the Board's challenging work programme and priorities. However, they are too recent to show impact yet.

194. The Board is committed to developing arrangements for a robust performance management framework to drive quality and improvement. The performance management and quality assurance sub-group reports to the business group on the outcomes and learning from audits, and this information helps to inform the priorities and work plan of the Board. There has been significant audit activity, including thematic and multi-agency audits which report on standards of practice and have helped to inform the Board's training programme and partner agencies' service development.

195. Section 11 audits are effective and closely follow the standards set out in guidance. The Board achieved a 100% completion rate of section 11 audits and has used the findings to improve safeguarding practice and identify multi-agency training and development needs for individuals and organisations. The process was well managed, and included follow-up compliance visits to agencies from Board members and the identification of areas for development for the training and improvement sub-group.

196. The Board's practice and the Chair's management of the serious case review process have improved significantly. In the period up to the appointment of the current independent Chair, there were a number of serious case reviews which were delayed in their completion. In addition, decisions not to initiate serious case reviews in the last three years were also reviewed by the Chair. This resulted in four additional case reviews being undertaken and one serious case review being changed to a practice review. The Chair's reasoning in each of these cases was discussed and agreed by the Board and Ofsted was notified. As a result, the criteria for initiating serious case reviews and practice reviews are now well understood and applied consistently by the sub-group and the Board. The learning from these cases has been integrated into the business plan of the Board and its sub-groups and action plans are monitored effectively by the business group. All actions and recommendations from completed case reviews have either been implemented, included in other parts of the Board's planning or have realistic timescales for completion and are regularly reviewed.

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197. The Board disseminates learning from serious case reviews and practice reviews widely through its website, newsletter and training and practice forums. Staff are aware of this activity and of the principle that learning from reviews informs training. However, few staff were able to identify specific improvements which were the result of local case reviews. This raises questions about the impact and quality of this training and the extent to which it is reinforced in practice, supervision and management oversight of cases.

198. The process for reviewing child deaths was too slow and has not been effective. The annual report was not completed on time. A new Chair was appointed for the Child Death Overview Panel (CDOP) during the year, and the panel has now produced a report as required by regulations, which provides relevant information and analysis of the small number of deaths considered. The improvements achieved during 2014–15 mean that the panel is in a position to ensure that future reports meet the standard expected by the Board.

199. During this inspection the LSCB provided timely notification to Ofsted of the death of a child who was known to partners and the local authority. Appropriate arrangements are progressing to inform decision-making about whether a serious case review is required.

200. The Board has held the local authority and partners to account for their performance over private fostering. Too few children are identified and referred to the local authority by partner agencies. The Board has increased its level of oversight in this area since the 2012 Ofsted inspection, when it was identified as an area of weakness. The local authority private fostering annual report to the LSCB shows that notifications have increased from 15 in 2012–13 to 20 in 2013–14. However, the Board has not received an update on progress in this area since the annual report was considered in May 2014 and cannot be assured that this continues to be a priority for partners.

201. The Board has a training strategy which is currently under review. Although the Board does provide some appropriate training, the range of this is limited. The Board does not have a dedicated training officer and there is a shortage of trained volunteer trainers from across the partnership in recent months. A number of courses have also been cancelled due to low take-up. The learning and improvement sub-group does not systematically collect information to allow it to evaluate the sustained impact of training on staff.

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202. During the inspection the Board re-launched its suite of procedures manuals, which have been refreshed through a commissioning arrangement. These are now accessible to all partners via the internet. The procedures are clear and fit for purpose and the Board has ensured that the commissioning arrangement allows for the procedures to be reviewed and amended twice per year to reflect changes in legislation, regulations and local policy. This process has been overseen by the Board's policy and procedures sub-group, which will also monitor and review its implementation. It is not yet possible to measure the impact of these changes on practice as they have only just occurred.

203. The annual report requires improvement. It lacks breadth and provides too little analytical detail about the range of responsibilities the Board. It does not provide a rigorous and transparent assessment of the effectiveness of local services. This is acknowledged as an area for improvement by the Chair, who is constrained by the fact that the reporting period was prior to her appointment.

204. The funding of the Board is shared by key partners and is detailed in the annual report. The level of financial support is sufficient and includes additional leadership capacity to support the improvement and development needs identified by the Board during the current year.

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What the inspection judgements mean

The local authority

An **outstanding** local authority leads highly effective services that contribute to significantly improved outcomes for children and young people who need help and protection and care. Their progress exceeds expectations and is sustained over time.

A **good** local authority leads effective services that help, protect and care for children and young people and those who are looked after and care leavers have their welfare safeguarded and promoted.

In a local authority that **requires improvement**, there are no widespread or serious failures that create or leave children being harmed or at risk of harm. The welfare of looked after children is safeguarded and promoted. Minimum requirements are in place, however, the authority is not yet delivering good protection, help and care for children, young people and families.

A local authority that is **inadequate** is providing services where there are widespread or serious failures that create or leave children being harmed or at risk of harm or result in children looked after or care leavers not having their welfare safeguarded and promoted.

The LSCB

An **outstanding** LSCB is highly influential in improving the care and protection of children. Their evaluation of performance is exceptional and helps the local authority and its partners to understand the difference that services make and where they need to improve. The LSCB creates and fosters an effective learning culture.

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.

An LSCB **requires improvement** if it does not yet demonstrate the characteristics of good.

An LSCB that is **inadequate** does not demonstrate that it has effective arrangements in place and the required skills to discharge its statutory functions. It does not understand the experiences of children and young people locally and fails to identify where improvements can be made.

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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 six of Her Majesty's Inspectors (HMI) from Ofsted and two additional inspectors (AI).

The inspection team

Lead inspector: Pauline Turner, HMI

Deputy lead inspector: Wendy Ghaffar, HMI

Team inspectors: Jon Bowman HMI, Sheena Doyle HMI, Ali Mekki HMI, Judith Nelson AI, Fiona Parker AI, Neil Penswick HMI

Quality assurance manager: Christine Williams

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Piccadilly Gate
Store St
Manchester
M1 2WD
T: 0300 123 4234
Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
W: www.ofsted.gov.uk
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