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]

Inspection date: 13 April 2015 – 8 May 2015

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Children's services in Peterborough require improvement to be good
There are no widespread or serious failures that create or leave children being harmed or at risk of harm. However, the authority is not yet delivering good protection and help for children, young people and families. The authority is not yet delivering good care for children and young people looked after. Leadership, management and governance require improvement. When any widespread or serious failures have been identified by the local authority they are being effectively addressed, but the characteristics of good leadership are not in place. It is Ofsted's expectation that all children and young people receive the level of help, care and protection that will ensure their safety and help prepare them for adult life.

1. Children who need help and protection		Requires improvement
2. Children looked after and achieving permanence		Requires improvement
	2.1 Adoption performance	Good
	2.2 Experiences and progress of care leavers	Requires improvement
3. Leadership, management and governance		Requires improvement

[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 Inspections 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.

Contents

The local authority

Local authority context

Previous Ofsted inspections

- The local authority operates three children's homes. All three were judged to be good in each of their most recent Ofsted inspections.
- The previous inspection of the local authority's safeguarding arrangements/ arrangements for the protection of children was in March 2013. The local authority was judged to be adequate. At the time of the two previous safeguarding inspections in 2010 and 2011, the local authority was judged to be inadequate.
- The last inspection of the local authority's services for looked after children was in May 2010. The local authority was judged to be good.

Local leadership

- The Director of Children's Services has been in post since March 2015. She is also the Director of Adult Services.
- The chair of the Local Safeguarding Children Board (LSCB) has been in post since February 2013.

Executive summary

While the local authority has taken action to address the recommendations made at its last inspection, its progress has been affected by safeguarding pressures, high turnover of managers and staff and a heavy reliance on agency social workers. This has resulted in some inconsistent practice and instability and drift for some children.

A new senior management team has quickly assessed the situation, identified what needs to be done and begun to put in place measures to accelerate progress. All middle and senior manager posts have now been filled on a permanent basis, which is a significant step forward. Social workers talk very positively about the changes that are being made and, in general, they are better supported. The new leadership team is moving the service in a positive direction and there are clear signs of improvement. However, frontline practice and management oversight are not yet consistently strong and it is too early to see the changes that have been made having a sustained impact on outcomes for children and young people. Leaders and managers are using audits well to identify areas for improvement, although action plans that result from this work are not always sufficiently robust. Performance management information is not sufficiently reliable to enable managers to identify and respond quickly to issues and areas of concern and shape strategic action.

For example, separate databases are used to record information about children missing from home, care and school. This has weakened oversight of this area of practice and the local authority and its partners are not yet able to assure themselves that every child who goes missing is offered a return interview. Leaders have acted to address this gap and have commissioned new services to provide return interviews. Children who are identified as being at risk of child sexual exploitation are appropriately safeguarded, although risk assessment tools are not used consistently to screen all those who are potentially vulnerable. A major joint operation with the police has recently resulted in perpetrators being convicted.

Inspectors saw some examples of robust assessments, good analysis of risks and strengths, and coherent plans leading to improved outcomes for children and young people. However, some assessments fail to explore concerns fully or to take proper account of the child's or parents' views. Too many of the plans seen for children in need of help and protection and looked after children lack an outcome focus or progress measures. Social workers do not consistently make effective use of chronologies. While they are supervised regularly, decision-making and management oversight of cases is variable and there is limited evidence of critical reflection.

Early help is well coordinated. A good range of responsive services is making a positive difference to children's lives and locality-based multi-agency support groups (MASGs) are ensuring that children and families receive timely support. However, in the absence of a formal neglect strategy, neglect is not given a sufficiently high profile across all agencies which means that some children are left at risk for too long. Of the last 10 children to become looked after, four, including three from the same family, had been allowed to remain in neglectful situations for longer than they

should. Once children are identified as living in private fostering arrangements they are well supported but recognition of private fostering situations by practitioners remains a challenge within both children's social care and across the partnership.

The multi-agency safeguarding hub (MASH) provides an effective and timely triage service. Strategy meetings are effective. Attendance at child protection case conferences has improved, although more needs to be done to ensure that school nurses and police officers regularly attend initial case conferences. Core groups are not consistently held within 10 days of the initial conference and in the last quarter 16% of review conferences were not held within agreed timescales. Inspectors found no evidence of children being harmed as a result of these delays. Some children's cases remain open to children's social care for longer than necessary when they could and should be 'stepped down' to early help.

Corporate parenting lacks rigour and ambition. Leaders are not sufficiently proactive in enabling looked after children to shape services and influence their decisions. Although looked after children attend good schools, their achievements are not consistently strong. The virtual school lacks sufficient capacity to monitor and improve education outcomes for looked after children, including those in post-16 education. Personal education plans lack effective targets and use of the pupil premium is not well monitored. Initial health assessments are not completed promptly and there is insufficient focus on children's mental health and wellbeing.

Good oversight at the edge of care helps ensure that decisions to look after children are appropriate. Most looked after children live in stable family placements within 20 miles of their homes. The number of looked after children who are offending has fallen. Care proceedings are completed quickly and children's reviews are timely. Most children contribute to their reviews and benefit from high quality advocacy services. Complaints are taken seriously. The quality of life story work is excellent.

The number of foster carers has increased year-on-year. Carers are well supported but the authority's records on carers are not consistently robust. More use needs to be made of family and friends placements. Disabled children have good access to short breaks accommodation; their parents are positive about the help they receive.

Adoption performance is good. All children for whom the plan is adoption are given the best chance to live with adoptive families. The numbers of adopter approvals and of children being placed for adoption continue to rise. The local authority demonstrates ambition and success in finding adoptive placements for older children, children with complex needs and groups of brothers and sisters.

Care leavers benefit from an effective 'staying put' policy. The vast majority live in suitable accommodation. However, pathway planning needs to improve and, at the point at which they leave care, young people are not being given comprehensive information about their health histories. The number of care leavers not in education, employment or training has reduced. Leaders recognise that more use needs to be made of apprenticeships to enhance care leavers' employment prospects.

Recommendations

1. Ensure that performance management information systems are fit for purpose, provide reliable data and enable managers to identify and respond quickly to issues and areas of concern.

2. Ensure that robust service and actions plans, informed by audit findings, are used to drive continuous improvement at every level.

3. Ensure that effective action is taken to increase the stability of the children's social care workforce.

4. Ensure that all staff receive regular good quality supervision which strengthens management oversight and challenge and provides opportunities for critical reflection.

5. Ensure that all assessments are informed by chronologies and include a clear and comprehensive analysis of needs and risks which results in effective plans.

6. Ensure that all child in need plans, child protection plans, looked after children plans, pathway plans and personal education plans are outcome-focused, easy to understand and include specific and measurable objectives.

7. Develop and implement a neglect strategy.

8. Ensure that the new child sexual exploitation risk assessment tool is used consistently and that information about children missing from home, school and care and/or at risk of child sexual exploitation is well coordinated, analysed and acted upon.

9. Ensure that that every child who goes missing from home or care is offered a return home interview and that the information obtained is used effectively to safeguard those children and young people and aggregated to identify themes and trends for the city.

10. Ensure that foster carers' files are of a consistently high standard and include all of the required documentation.

11. Ensure that initial health assessments are routinely completed within 28 days of a child or young person becoming looked after and that health assessments and care plans take full account of children's emotional health and well-being.

12. Ensure that there is a more robust approach to corporate parenting and that elected members and senior managers listen to, and act on, the experiences of children and young people in order to improve their lives.

13. Further develop the role of the Children in Care Council to help make this happen.

14. Ensure that the virtual school has sufficient capacity to monitor and improve education outcomes for looked after children, including those in post-16 education.

15. Ensure birth relatives of children who are being adopted can access independent counselling and support without excessive delay.

16. Ensure that, at the point at which they stop being looked after, all care leavers have access to comprehensive, accessible information about their health histories.

17. Strengthen care leavers' engagement in their pathway plans and their awareness of their rights and entitlements.

18. Make greater use of apprenticeships to increase opportunities for care leavers.

19. Ensure that learning from children's complaints is used to shape and inform frontline practice and influence service improvements.

Summary for children and young people

- There are some effective services for children and their families when they need help, especially when problems first arise.
- There have been too many changes of staff. This makes it hard for children and young people to get to know their social workers properly and feel confident with them. Managers are taking action to improve this.
- Plans are not always written in a way that makes it easy for children and young people to understand who is going to do what and when to help them.
- Police and social workers work well together to protect children and young people who are being sexually exploited.
- People who work with children need to do more to make sure that they combine information about children who are missing from education with information about children who are missing from home, care or are at risk of being sexually exploited.
- Most children and young people who are not able to live with their own families are living with foster carers.
- When it is not safe for children and young people to ever go home, more of them are being found new families.
- When they leave care, young people do not always get enough information about their health histories.
- Senior leaders and managers need to be better at using information about the experiences of children and families and how well social workers support them.
- A new group of senior managers is starting to make a real difference.

Information about this local authority area[2]

Children living in this area

- Approximately 45,817 children and young people under the age of 18 live in Peterborough. This is 24% of the total population in the area.
- Approximately 23% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 21% (the national average is 17%)
  - in secondary schools is 15% (the national average is 15%).
- Children and young people from minority ethnic groups account for 27% of all children living in the area, compared with 22% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Asian or Asian British and Mixed.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 37% (the national average is 19%)
  - in secondary schools is 28% (the national average is 14%).
- Peterborough is the second fastest growing city in England. It includes a variety of inner-city and rural areas, the former being associated with higher density housing and a more diverse and faster growing population. There are year-on-year increases in the numbers of children and young people attending Peterborough schools; the number of pupils increased by 4% between October 2013 and October 2014.
- Peterborough has an increasingly diverse population; 153 languages are spoken in Peterborough schools. There is a growing number of children and families moving to the city from central and Eastern Europe.
- The largest minority ethnic group of pupils is still Asian Pakistani, reflecting earlier patterns of migration. However, this group as a proportion of the school population is now relatively stable, while the population of Polish and Lithuanian children in Peterborough schools increased by 19% and 13% respectively between October 2013 and October 2014.

Child protection in this area

- At 31 March 2015, 1,860 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 1,765 at 31 March 2014.

[2] The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data where this was available.

- At 31 March 2015, 227 children and young people were the subject of a child protection plan. This is a reduction from 239 at 31 March 2014.
- At 31 March 2015, the number of children living in a privately arranged foster placement was eight. At 31 March 2014, there were fewer than five children living in such placements.

Children looked after in this area

- At 31 March 2015, 354 children are being looked after by the local authority (a rate of 78.7 per 10,000 children). This is a reduction from 365 (80 per 10,000 children) at 31 March 2014. Of this number:
    - 174 (or 51%) live outside the local authority area;
    - 20 live in residential children's homes, of whom 83% live out of the local authority area;
    - three live in residential special schools,[3] of whom all live out of the local authority area;
    - 273 live with foster families, of whom 51% live out of the local authority area;
    - 10 live with parents, of whom one lives out of the local authority area;
    - 12 children are unaccompanied asylum-seeking children.
- In the last 12 months:
    - there have been 32 adoptions;
    - 27 children became the subject of special guardianship orders;
    - 169 children ceased to be looked after, of whom 1% subsequently returned to be looked after;
    - 36 children and young people ceased to be looked after and moved on to independent living;
    - no children and young people ceased to be looked after and are now living in houses of multiple occupation.

[3] These are residential special schools that look after children for 295 days or less per year.

The experiences and progress of children who need help and protection

The experiences and progress of children who need help and protection	Requires improvement

Summary

Early help to families is well coordinated, with a good range of responsive services available and these make a positive difference to children's lives. Early help assessments are good and local multi-agency safeguarding groups (MASGs) ensure that children and families receive the support they need.

When concerns for children are raised with children's social care, the multi-agency safeguarding hub (MASH) provides an effective and timely triage service. Children in need of protection benefit from coordinated multi-agency action. Arrangements for protecting children outside office hours work well.

Case records show that social workers visit and see children regularly. The quality of practice in the first response and family support teams is too variable, in part as management oversight and supervision are not yet of a consistently good standard. Social workers do not consistently make effective use of chronologies to understand key events in children's lives. Some assessments fail to explore concerns in sufficient depth or to take account of children's and parents' views. Some plans are vague in their objectives, making progress difficult to measure.

Attendance at initial child protection case conferences has improved significantly, although further work is required as school nurses and police officers do not attend in a small number of cases. This means that a valuable source of information can be lost. Inspectors found delays in some initial core group meetings and review case conferences, although subsequent core groups do meet at appropriate intervals and no cases were seen where such delays resulted in harm for children.

In a small number of cases there was evidence that past delays have resulted in children remaining in neglectful situations for too long. Some cases remain open to children's social care past the point when social work intervention is needed, but in a small number of others a decision to 'step down' had been taken prematurely and early help services were not able to make the changes that had been optimistically expected. Some children experience too many changes of social worker and, as a result, progress has not happened quickly enough for them.

Good partnership work supports action to manage high level risk from domestic abuse. Children who are recognised as vulnerable to sexual exploitation are protected and perpetrators have successfully been prosecuted. However, oversight has not been sufficient to ensure consistent screening of all of those potentially at risk of CSE and return interviews for those who go missing from home. Action is needed to bring together and analyse management information which is currently held in separate databases about children missing from home, care and education.

Inspection findings

20. The local authority has commissioned a wide range of early help services which are effective in reducing the need for statutory intervention. Early help to families is well-coordinated and partners have worked well together to improve the quality and effectiveness of services. The local authority has recently negotiated with children's centre providers to implement a more targeted approach and extend their offer to include work with families where there are children up to the age of 12 years. This promotes a more holistic approach to the needs of families. There is a good quality assurance process, informed by feedback from parents and carers, which evaluates the quality and impact of support provided. An electronic system for recording early help assessments, introduced 18 months ago, works well and assessments are good. They provide a detailed picture of the needs of children and families and how they will be met.

21. The three locality-based, multi-agency support groups (MASGs) are effective in mobilising and coordinating partners' responses to assessed need. Meetings are chaired well, information about children's and families' needs is shared appropriately and MASG members challenge each other effectively. MASGs ensure children and families receive the right level of support in a timely way and are 'stepped-up' appropriately from early help to children's social care when needs or risks increase.

22. When concerns about children and families are raised with children's social care, the MASH provides a timely and effective initial response. An experienced and qualified senior social work practitioner directs and coordinates information-gathering and makes recommendations about the action required, including whether or not the contact should be referred to children's social care for assessment by a social worker. Decisions are proportionate and timely, and are made by a suitably qualified team manager. An early help worker, based in the MASH for part of each day, offers advice on whether the needs of families can be met by early help services and supports the early help assessment process. Since this arrangement started four months ago, over 200 contacts that have come into MASH which do not meet the threshold criteria for children's social care services have been diverted to early help. Case sampling by inspectors showed that these decisions to divert contacts to early help are appropriate.

23. Managers in the first response and MASH teams make good use of tracker tools to monitor the progress of assessments and case work. The new senior management team has very recently acted to improve workflows and ensure that caseloads in the first response team are manageable. This includes a temporary injection of additional staff in order to increase capacity and to enhance support for social workers to help them develop the necessary skills to progress work more quickly. It is too early to tell whether this improvement will be sustained.

24. The MASH is effective in determining the urgency with which assessments are required. In March 2015, the Corporate Director authorised the head of service to delay, at exceptionally busy periods, the allocation of assessments in cases screened as low-level need, in order to help manage workflow. Although such cases are screened and re-evaluated daily, the children concerned experienced a brief delay in having their needs assessed, even though their assessments were completed within statutory timescales. This facility had been used once up to the time of this inspection. There were no unallocated assessments at the time of the inspection.

25. Children who are found to be in need of protection receive a prompt service, with child protection cases processed by the MASH within four hours of initial contact. Strategy meetings involve a good range of agencies and decisions are clear and carefully recorded. Child protection enquiries are timely and thorough. Children are seen alone. The local authority routinely samples and audits some of the cases where child protection investigations have not resulted in an initial child protection conference to ensure that thresholds are being applied consistently and appropriately.

26. Arrangements for protecting children outside office hours work well. The emergency duty team (EDT) service is commissioned from Cambridgeshire County Council. Improvements made following the Ofsted inspection of Cambridgeshire in June 2014 include the establishment of a dedicated team of children's social workers as part of the EDT. Senior managers from Peterborough provide good support to out-of-hours staff on a rota basis and communication between the EDT and daytime services is effective. Staff working in the EDT have access to Peterborough's children's electronic records, which aids decision-making. The EDT manager audits a sample of cases every month in order to assure the quality of work.

27. The quality of practice in the first response team is too variable. While inspectors saw some thorough assessments, with sound analysis of risks and strengths and coherent plans, too many assessments fail to explore concerns fully or to take proper account of the child's or parents' views. Inspectors tracked 30 cases of which four assessments were inadequate and 17 required improvement, leaving nine which were good. Too many of the plans are not sufficiently outcome-focused and lack progress measures.

28. The local authority has acted on the findings of a 2014 audit which found that only 40% of chronologies were of a good standard. There has been some improvement but social workers are still not making effective use of chronologies. The majority of those chronologies seen by inspectors do not provide an up-to-date summary of key events in the child's life. This makes it difficult for social workers and their managers to understand and analyse the significance of past events, particularly in cases involving chronic neglect.

29. The quality, frequency and regularity of supervision that social workers in the first response and family support teams receive are not yet consistently good.

The high turnover of managers in these teams has been a significant contributory factor. Permanent appointments have now been made. While supervision generally covers immediate casework issues, the opportunity to review the overall progress of cases is missed. This means that patterns and trends may not be spotted and can lead to delay in taking decisive action to meet needs and provide protection.

30. Social workers visit children regularly and case recording is generally up to date. All children in need and child protection cases seen by inspectors have plans and most contain a range of actions to safeguard children and reduce risks. However, too many plans are not sufficiently outcome-focused and the lack of specific, measurable objectives makes it difficult to measure progress in improving children's lives. This lack of focus contributes to the drift observed in some cases.

31. Historically, attendance by partner agencies at child protection conferences has been poor. There has been a noticeable improvement over the last 12 months, although conference chairs report that school nurses do not always attend conferences or core groups, which means that a valuable source of information is lost. In a small number of cases the police do not attend initial child protection conferences. Although they do send reports, the information they contain is not always clear or up to date.

32. There is some evidence of variable practice in the timely convening of initial core groups. A recent audit by the local authority found that they were held within 10 working days of the initial child protection conference in less than half of the cases considered, although an audit into the effectiveness of core groups undertaken by the Local Safeguarding Children Board found that in 16 cases, 14 were held within 10 days. Where initial core groups are not held within 10 days, there are delays in finalising child protection plans and developing a coordinated response. Inspectors found that in most cases subsequent core groups take place at appropriate intervals and are attended by most relevant professionals.

33. Between April 2013 and December 2014, the timeliness of child protection reviews was in line with comparator local authorities, with almost all reviews taking place on time. There has been a decline in the first quarter of this year, with reviews for five children not being held within timescales, although inspectors saw no cases where such delays resulted in harm or additional risk of harm for children.

34. Child protection conference chairs make good use of case alerts to raise concerns about practice. The case alert system is usually effective in ensuring that remedial action is taken quickly enough for the child.

35. At the time of the inspection, 252 children were the subject of a child protection plan. Some 65% of plans were made under the category of neglect; 25% emotional abuse; 5% physical abuse; and 1.6% sexual abuse, with the

remainder having a plan under more than one category. The very low figure for the category of sexual abuse excludes child sexual exploitation cases. Where child protection plans have been required in these cases, they have generally been made under the categories of neglect or emotional abuse. This has the potential to mask the true nature of risk, although in the cases seen suitable plans are in place to monitor and reduce risks for the young people concerned.

36. In most cases, child protection plans are effective in reducing risks for children. As a result, the proportion of children with a second or subsequent child protection plan is, at 12.5%, lower than the average for comparators. The proportion of children who have had a child protection plan for more than two years (2%) is also lower. In cases seen by inspectors, decisions to end child protection plans were appropriate.

37. Inspectors examined the cases of the last 10 children to become looked after. In four of these (three from the same family), children re-entered care having previously returned home. Delays in convening legal planning meetings and completing assessments meant that they had been left in neglectful circumstances for too long. The new senior management team has taken action to improve oversight of such cases and inspectors saw evidence of a positive impact in the most recent cases that were both tracked and sampled. Recent improvements in pre-proceedings work have led to good decisions for some children. However, these changes are very recent and it is too early to know if they will be sustained.

38. Some children, young people and families remain open to children's social care for longer than necessary when they could and should be 'stepped down' to early help services. This has an impact on the size of social workers' caseloads and contributes to drift and delay for some children and families. In a small number of other cases where concerns had not warranted a child protection plan, a decision to 'step down' had been taken prematurely and early help services were not able to achieve the changes required and hoped for, resulting in a swift re-referral to children's social care. This is a reflection of the poor standards of assessment and planning seen in some cases.

39. Some children have experienced too many changes of social worker. This has made it more difficult for them and their families to build stable, trusting relationships with their social workers. In some cases it has caused delays in achieving the necessary progress.

40. The local authority's Direct Intervention Service works alongside children's allocated social workers, providing intensive support for families where children are subject to child protection and child in need plans. This service gives practical support within the home and models positive parenting. It is available outside normal working hours, at times when families are in need of higher levels of support. Families do not have to wait for an assessment to be completed before this additional help is made available.

41. The inconsistent use of the child sexual exploitation risk assessment tool means that not all of those potentially at risk have been screened and therefore risk may not have been identified. The local authority and its partners have identified 39 children at risk of child sexual exploitation and all of these cases have an allocated social worker. Risk to these children is regularly reviewed with partners and through management supervision. In a sample of cases involving children at risk of sexual exploitation, suitable plans were in place to reduce those risks. A new, revised multi-agency child sexual exploitation risk assessment tool was due to be introduced in June 2015.

42. In cases seen by inspectors, there was a good response to young people who went missing from home, with return interviews offered and completed, and subsequent work with the whole family to try to prevent recurrence. However, not all young people who have gone missing are offered return home interviews; this is a missed opportunity to intervene at the individual level and to gather intelligence. The database used by the local authority to record information about missing children makes it difficult to differentiate between those who are missing from home and those who are missing from care. It also makes it difficult to identify whether return home interviews have or have not taken place. An entirely separate database is used to track children missing from education.

43. These factors limit the ability of the local authority and its partners to identify trends, links and patterns in order to protect children and disrupt criminal behaviour. The local authority has very recently moved to strengthen those arrangements by commissioning a large voluntary sector organisation to undertake return home interviews with children and young people who have gone missing from home. Co-locating the worker in the MASH, with easy access to the police and other partners, will benefit missing children by making it easier for professionals to work together and share information. A bi-monthly meeting of officers is also now taking place to bring information together about children missing from care, home and education and child sexual exploitation. However, it is too early to see any impact from the changes.

44. Inspectors found that, at the time of the inspection, 427 children were missing from education. This is a high number for an authority of this size. However, it is recognised that this relates partly to the number of children from other countries in the local area, at least some of whom are likely to have returned to their countries of origin. Their names remain on the children missing education register unless the local authority has definitive proof that the child is in school elsewhere or is no longer living in the country. If not, the local authority checks national data for a period of two years and only then removes the name from the list.

45. At the time of the inspection, 209 children were being electively home educated in Peterborough. The local authority offers a home visit and provides appropriate support where families need help.

46. When young people aged 16 and 17 present as homeless they are offered support from a commissioned provider to help them return to their families. When it is not possible for them to return home, and there is a danger that they would otherwise become homeless, the local authority will offer them accommodation under section 20 of the Children Act 1989. In the year April 2014 to March 2015, 21 young people aged 16 or 17 became looked after.

47. Cases tracked demonstrate that the local authority designated officer responds quickly to referrals, provides good advice and guidance to organisations and has built strong relationships with the police and designated safeguarding leads in partner agencies. Increasing numbers of referrals in recent months are putting pressure on the capacity of the designated officer and causing some administrative delays, for example in checking minutes. There are plans to increase administrative support to this service to prevent delays during busy periods.

48. All domestic abuse incidents are effectively triaged through the MASH. Risks are assessed using the domestic abuse, stalking and honour based violence (DASH) tool and referred to the multi-agency risk assessment conference (MARAC) when appropriate. These meetings are well led by Cambridgeshire police, and well attended by representatives from an appropriate range of partner agencies, including an advanced practitioner from the first response team. Domestic abuse cases tracked during the inspection demonstrate effective multi-agency action to protect children.

49. Children, young people and adults, including children and young people who are affected by parental substance misuse, have access to a range of well-resourced drug and alcohol services. A local voluntary sector organisation offers counselling to young people affected by substance misuse in their families as well as support and treatment for young people who have substance or alcohol misuse problems of their own. As of December 2014, 131 young people were being supported by the young people's treatment service.

50. Notifications to the local authority of private fostering arrangements have increased slightly in the past year, but remain low. As of March 2015, four private fostering arrangements had been identified, involving eight children. A campaign to raise awareness of private fostering by targeting schools and GPs, uses materials in five community languages, although it does not currently provide information for young people and children themselves. Once private fostering is recognised, the children concerned receive a good service. Assessments of suitability are thorough, children's needs are carefully considered and social workers visit regularly, seeing children and carers separately and providing appropriate support. In cases where the arrangement is not approved, the child is deemed to be a child in need and suitable alternative services are provided.

The experiences and progress of children looked after and achieving permanence

Key judgement	Judgement grade
The experiences and progress of children looked after and achieving permanence	**Requires improvement**

Summary

While most looked after children attend good schools, their achievements are not consistently strong and the virtual school lacks capacity to monitor all aspects of their education. Personal education plans lack effective targets and there is insufficient oversight of the use by schools of the pupil premium. Initial health assessments are not always on time and do not focus enough on children's emotional wellbeing.

Good oversight at the edge of care helps ensure that decisions to look after children are appropriate. Most children live in stable placements with families. Care proceedings are completed quickly. Most children see their social workers regularly and have good relationships with them, although care leavers have mixed views about the support they receive. Too many children's plans lack overarching, long-term goals and chronologies are not used effectively. Children's reviews are timely and most children contribute to them. They benefit from high quality advocacy services and complaints are taken seriously. The quality of life story work seen by inspectors is excellent. The number of foster carers has increased incrementally year-on-year and carers are well supported. However, carer records are not consistently complete. There is good access to short breaks for children with a disability and parents are positive about the help they receive.

The number of looked after children who are offending has fallen. When children go missing they are offered return home interviews, although data is not used effectively to analyse risk and inform prevention. All children for whom the plan is adoption are given the best chance to live with adoptive families. The numbers of adopter approvals and children placed for adoption continue to rise. The authority is successfully placing older children, brothers and sisters and those with complex needs. Birth relatives of children being adopted wait too long to access support.

Pathway planning for care leavers needs to improve. These young people are not sufficiently aware of their health histories and of their rights and entitlements. Elected members and senior officers are not consistently enabling them to shape services and have their say in decisions which affect them. The proportion of 16–18 year olds who are not in education, employment or training has reduced, although not enough use is made of apprenticeships for care leavers. The very large majority (95%) of care leavers live in suitable accommodation and the use of 'staying put' arrangements is well established and is improving young people's life chances.

Inspection findings

51. At the time of the inspection, 354 children and young people were being looked after by the local authority. Over the last three years, the rate of looked after children in Peterborough has been consistently higher than both national and comparable authority rates.

52. Chaired by the assistant director, the Peterborough Access to Support Panel (PASP) provides good oversight of children on the edge of care. The presence on the panel of a commissioning manager means that services and support are mobilised quickly in order to avoid the need for children to come into care unnecessarily. However, family group conferences are not being used proactively to prevent family breakdown or explore other ways of safeguarding children without the need for them to be looked after. The local authority had already begun to take action to address this prior to the inspection.

53. The majority of children who become looked after live with families; very few (6%) live in residential care. Most looked after children live near to their homes; currently 21% (85 out of 395) are placed more than 20 miles from their homes. This is a higher proportion than both the comparable authority average (13%) and the England average (16%). However, this is largely attributable to the fact that Peterborough is a small unitary authority surrounded by large tracts of rural counties.

54. The number of looked after children placed more than 50 miles from Peterborough is 42 (12% of the total). These arrangements are well-researched, well-planned, well-monitored and supported. Decisions to place children at a distance from the local authority are based on thorough assessments of need and require senior manager approval. They are only made in the most complex cases involving children who need significant additional support. Social workers and independent reviewing officers (IROs) visit these children regularly and ensure that appropriate arrangements to meet their education and health needs are in place prior to placement. The local authority applies rigorous quality assurance in the procurement and monitoring of independent sector placements.

55. Placement stability is good. Children and young people do not move unless the plan is for them to do so. Only 8% of looked after children (30 out of 354) have experienced three or more placement moves compared with the 2013–14 England average of 11% and comparable authority average of 11%. This means that children have the opportunity to form positive, enduring relationships with their carers and, as a result, are more likely to feel secure and to thrive.

56. Good quality legal advice means that as soon as a child starts to be looked after, appropriate decisions are made about whether to offer accommodation under section 20 of the Children Act 1989 or to apply to the courts for a care

order. Children who are accommodated under section 20 are regularly reviewed by senior managers. Inspectors found no evidence of drift in these cases.

57. The need for permanence for children who are unable to return to their parents' care is routinely considered at an early stage. All options for achieving permanence are explored, including the use of special guardianship orders (SGOs) with family members or foster carers. In 2014–15, 27 children (13%) left care with permanence secured through an SGO. The local authority is developing a positive reputation for its work with foreign embassies in exploring all of the permanency options available for children whose families are originally from eastern European countries.

58. While the special guardianship policy is up to date and is clear and explicit about the need for an effective support plan, it lacks any specific guidance about what that support should look like. Inspectors saw some evidence of a lack of consistency in the support provided to special guardians.

59. While most looked after children live in a family environment, family and friends foster carer households account for only 10% of the total (13 out of 130 foster care households), compared with the England average at 31 March 2014 of 13%. However, this figure needs to be considered alongside the relatively high number of SGOs and does not necessarily indicate that the local authority is making insufficient use of family and friends placements.

60. Children's profiles are used effectively to ensure that there is a good match between what individual children and young people need and what foster carers can provide in terms of their skills, knowledge and experience. Robust sibling assessments mean that brothers and sisters are placed together when this is the right thing for them. Over the course of the last two years, the number of children matched permanently to their foster carers has almost doubled, increasing from 18 in 2013–14 to 30 in 2014–15. Of the 30 children permanently matched in the last year, 14 were matched with independent fostering agencies' carers. This demonstrates the local authority's commitment to ensuring that, where there is a positive match, children are able to remain with their foster carers.

61. The fostering and permanence panel ensures a robust approach to the approval and first review of foster carers and the process of matching foster carers to specific children. A good level of scrutiny is evidenced in the panel's minutes. When children are being matched to permanent foster carers the children are encouraged to attend the panel. All children and young people who are matched to a permanent foster home receive a letter and certificate from the agency decision-maker to celebrate the permanence of their placement. This is good practice.

62. Care is taken to recognise and respond to each child's unique identity by taking account of factors such as ethnicity and disability. While not all placements are culturally matched, stringent efforts are made to ensure carers have the

necessary skills and experience to meet the diverse needs of children and young people and provide sensitive and appropriate responses.

63. Good working relationships between children's social care, the Children and Family Court Advisory and Support Service (Cafcass) and the judiciary mean that care proceedings are completed with minimum delay. Legal services are proactive in advising and assisting social workers from the outset, ensuring that evidence is well presented in order to achieve the best outcome for the child. The quality of court assessments is good. At 28 weeks, the average length of care proceedings is better than the national average of 30 weeks.

64. The high staff turnover that affects the first response and family support teams does not affect the looked after children teams to the same extent. As a result, many looked after children develop sustained relationships with social workers who know them well. The very large majority of looked after children see their social workers regularly, although statutory visits are not always completed on time. Almost all (97%) of the 99 children and young people who responded to the council's looked after children survey in December 2014 said they were happy with their social workers.

65. Although children are well supported by their social workers and foster carers, their care plans are not always informed by an up-to-date assessment. Too many care plans lack overarching long-term goals, but despite this the local authority is successful in achieving permanent substitute families for its looked after children. Chronologies are not used effectively to record significant events in children's lives. Social workers know their children well, and are able to apply that knowledge to help provide the right care for them, but case records, the quality of the direct work or how that work relates to plans for their futures does not always accurately reflect this. This makes it more difficult for managers to check that the necessary work is being done.

66. A lack of up-to-date assessments means that a small number of children have returned home from care without the right level of support in place. Inspectors found that in two cases (1% of children who returned home in the 12 months preceding the inspection), plans lacked sufficient detail about how children, parents and carers would be supported or about the arrangements for monitoring and reviewing the children's health and well-being once they returned home. In one of these cases, the children returned home without any significant change in the poor home conditions. The local authority was monitoring the situation closely and took appropriate and decisive action during the inspection to protect the children.

67. Independent reviewing officers (IROs) ensure that children's reviews take place on time. Their oversight and challenge is increasingly robust, although more needs to be done to identify and challenge poorly written assessments and plans which do not address children's needs effectively. Action is being taken to address the areas for improvement identified in the 2015 IRO annual report and the local authority's self-assessment. This is increasing scrutiny of children's

plans and challenge where there is evidence of drift and delay, or where plans and assessments do not accurately reflect the child's needs.

68. Children and young people have regular contact with parents and family members. However, plans are not always clear about how contact will be managed, reviewed and supported and there is limited written evidence to show how contact arrangements relate to the developmental needs and routines of the child.

69. The majority (85%) of looked after children attend a school rated as good or better by Ofsted. School attendance of looked after children is in line with attendance for all children nationally. However, the educational attainment levels of looked after children vary significantly and are often too low. The educational achievement, and progression, of young people studying beyond school leaving age is good. Many of these are studying at the local GFE college. The proportion of young people who completed their programmes has risen from 82% in 2012/13 to 88% in 2013/14.

70. The virtual school lacks sufficient capacity to monitor all aspects of looked after children's education. Data are not used effectively to analyse the achievement of looked after children, annual reports are not sufficiently incisive in their analysis of performance and the progress of looked after children in school sixth forms is not sufficiently well monitored. Additionally, not enough support is provided for schools to ensure that all children have effective personal education plans with appropriate targets. Use of the pupil premium by schools is not well monitored. Senior managers have recognised this and are bringing in new monitoring and reporting arrangements for the pupil premium.

71. Although every looked after child has an annual health review, only 90% are completed within timescales. In 2014–15 only 11% of looked after children had an initial health assessment within 28 days of becoming looked after. Having identified that this failure to identify and assess children's health needs in a timely way is a significant omission, the local authority has, in consultation with its health partners, taken action to address the issue but the full impact of this has yet to be seen: in the first three months of this year, the proportion of children whose initial health assessments were completed on time had risen to 35%, clearly still not enough but showing an improving trend. In the case of looked after children who are living out of area, the looked after children health nurse will, if necessary, visit them in placement to ensure that their annual health assessments are completed.

72. The local authority no longer uses strengths and difficulties questionnaires to identify and assess the emotional health and well-being of looked after children, believing that this can be done better through the annual health assessment process. However, a sample of seven health assessments showed that children's emotional needs were not addressed sufficiently and that where issues were identified, action plans did not always indicate how those needs would be met. This approach is not consistent with national guidance. It fails to

identify and provide an appropriate response to the needs of looked after children and represents a missed opportunity to influence and inform targeted service provision.

73. Looked after children are well served by the looked after children psychology service, which is provided by the local authority. This service is a real strength and provides valuable support for children, foster families and residential care workers. Foster carers in particular speak very highly of the service and some foster carers are clear that it has helped to prevent placement breakdown. This provision goes some way to mitigate the impact of the lengthy delays in being able to access specialist support provided by child and adolescent mental health services (CAMHS).

74. The number of looked after children who have been cautioned for, or convicted of, an offence has fallen. In 2010–11, 7% of looked after children had been cautioned or convicted. The figure for 2014–15 is 1%. This success has been achieved through close partnership working with youth engagement services, making it possible to identify and target young people engaged in crime or most at risk of offending.

75. The success of Operation Erle[4] means that there is a high level of awareness across all agencies of child sexual exploitation. Schools, foster carers and residential care staff have all had training on child sexual exploitation. Risks are assessed and inspectors saw evidence of appropriate action being taken to safeguard and protect looked after children identified as at risk of sexual exploitation.

76. When looked after children go missing they are offered return home interviews. Where required, child protection strategy meetings are held. Recently, these arrangements have been strengthened to improve the quality of return home interviews and ensure that the information and intelligence gathered is used effectively to safeguard and protect children and young people both individually and collectively. A voluntary organisation has now been commissioned to ensure that return home interviews are undertaken independently of children's carers and social workers. It is too early to measure the effectiveness of these new arrangements, which came into force on 1 April 2015. Although appropriate steps are taken to respond to looked after children who go missing, not all children's plans comply with the amendments to the Care Planning, Placement and Case Review (England) Regulations 2014, which explicitly state that when a child goes missing from a placement their child care plan must describe what will be done to keep them safe.

77. The local authority recognises that the database currently used to track children who are missing from care or at risk of child sexual exploitation does not

[4] Operation Erle was a major joint operation with the police, focusing on child sexual exploitation, and involved 10 prosecutions in the last 12 months leading to a series of high-profile convictions.

facilitate analysis of the risks and trigger factors or make it easy to identify trends, links or patterns in a way which might inform preventive action. Information has to be manually extracted from the database and there is no mechanism for highlighting when the risk of child sexual exploitation has been identified or to show whether or not a risk assessment has been completed. While inspectors did not see any cases where risks associated with going missing or child sexual exploitation were not identified or acted on, the local authority needs to develop a more robust and systematic approach to the collection, management and analysis of information. A missing from home and care coordinator has been in post since 1 April 2015, but it is too early to evaluate the impact of that appointment.

78. Looked after children's reviews are held on time. The right of children to be consulted about the decisions that affect them is taken very seriously by social workers and IROs. In the last year, the vast majority (98.5%) of looked after children aged four or over contributed to their reviews, either in person or through an advocate or trusted adult. Recently, a small number of young people have chaired their own reviews, enabling them to make a meaningful contribution to the planning process.

79. Children and young people benefit from a high quality advocacy service commissioned through a voluntary organisation. They are actively supported to participate in child protection conferences and looked after children reviews, either in person or through an advocate, so that their voices are heard and can be acted upon. Independent visiting services are provided by a voluntary organisation. Currently, 19 looked after children have access to an independent visitor (IV). There are no children waiting to be matched with an IV.

80. Complaints are taken seriously and are investigated quickly and sensitively. However, while children and young people are actively encouraged to make use of the complaints procedure, the local authority needs to do more to ensure that learning from complaints is used to shape and inform frontline practice and influence service improvements.

81. The local authority has been very successful in recruiting in-house foster carers while at the same time maintaining high standards of foster care. Effective recruitment means that the number of foster carers has increased incrementally year-on-year. In 2014–15, 29 new fostering households were recruited. During the same period, 22 fostering households had their approvals terminated, leaving a net gain of seven new fostering households. The local authority has also now adopted a more targeted approach to recruitment aimed at recruiting foster carers for specific cohorts of children, including, for example, children from eastern European backgrounds.

82. Foster carers feel well supported by their supervising social workers. The vast majority of annual reviews are held within timescale. There is a clear expectation that foster carers demonstrate the skills required to meet the needs of the children they care for. To date, 89% (190 out of 213) of in-house

mainstream foster carers have completed Training Support and Development Standards (TSDS) or equivalent, leaving 11% who are more recent starters and have yet to complete the TSDS.

83. Foster carers' files are not of a sufficiently good standard and do not reflect the quality of support they receive. In too many cases seen, the records of supervisory visits are poor and lack sufficient detail to show how the carers' skills are used to improve outcomes for children and young people. Records do not show how foster carers' learning needs are addressed, or what follow-up action has been taken in response to concerns that have been identified. In some cases key documents are absent from the files.

84. Placement plans do not contain sufficient detail about the routines of the child or how their needs will be met, and when children move placement plans are not routinely updated. This means that new carers are not always clear about children's needs or what is expected of them as carers. This has the potential to undermine the quality of care children receive and is particularly important for children with disabilities because many of them are not able to communicate their needs and wishes.

85. The quality of life story work seen by inspectors is excellent. A dedicated life story worker, operating across both looked after teams, ensures that every child who has a plan for permanence has a carefully considered and well-crafted life story book. This enables children to develop an understanding of their history, and the reasons for their permanent separation from their birth families, at a pace that suits them.

86. The Children in Care Council (CiCC) is still relatively new and has not been given the support it needs to reach out to all children in care and represent their views. Of the 99 respondents to the 2014 looked after children survey, less than one third (31%) had heard of the CiCC. A dedicated participation worker has now been appointed to support the development of the CiCC.

87. There is good access to short breaks accommodation for children with a disability. Parents and carers are positive about the service and support they receive from the local authority.

The graded judgment for adoption performance is that it is good.

88. All children with a plan for adoption are given the best chance to live with adoptive families; this includes children with complex needs and groups of brothers and sisters. The number of children achieving permanence through adoption has increased. In 2014–15, 32 children were adopted, seven more than in the previous year.

89. Children are being placed more quickly with adoptive families. While children with complex needs and sibling groups generally wait longer, young babies move to their adoptive families at the earliest opportunity, through foster to adopt arrangements. Overall, the local authority is performing better than both its statistical neighbours and the national average in the length of time between children entering care and moving in with their adoptive families. The three-year average wait of 593 days in 2011–14 compared very favourably with the national average of 628 days and statistical neighbour average of 616 days. In 2012–15, the local authority has further reduced the average time children wait between entering care and moving in with their adoptive families to 544 days.

90. The authority demonstrates determination and ambition in wanting to place older children, children with complex needs and groups of brothers and sisters in adoptive families. In 2011–14, Peterborough was performing at below the national and comparable authority average rates for placing older children (8% and 5% respectively). The authority's own data for 2012–15 show a significant improvement with a figure of 14%, though it was not possible at the time of the inspection to compare this with other authorities because the data are not yet published. In the last year, nine of the 32 children who were adopted were aged between five and 10 years.

91. In 2014–15, 10 groups of brothers and sisters were placed together in adoptive families compared with five groups in 2013–14. No children were placed apart where the plan was for them to remain with their brothers and sisters. Together-or-apart assessments ensure that plans are well-considered and based on children's relationships with each other. This is helping children to keep and sustain important life-long relationships.

92. The adoption scorecard shows that Peterborough takes slightly longer to match children with adoptive families compared with their statistical neighbours and the national average. The three-year average for 2011–14 from court approval to place a child for adoption and the child being matched with their adoptive family was 242 days. This compared to a statistical neighbour average of 211 days and an England average of 217. The latest data show that, for the period 2012–15, the length of time taken from approval to matching has increased slightly to 249 days. However, further analysis shows that this reflects the local authority's ambition and success in finding adoptive families for older children

and for brothers and sisters together, as well as enabling children to be adopted by their foster carers.

93. A number of children have had their plans for permanence changed from adoption. In all cases, assessments have been undertaken to ensure that the change in plan is appropriate for the child and reflects their needs. To date, nine children have had their placement orders revoked. A further 26 children are due to have their orders revoked over the next two months. This leaves only four children who are waiting for adoption who have not yet had an identified match. Very few children (three out of 26) have experienced any disruption as a result of the changes to their permanence plans. Continuity of care provides them with stability and security.

94. A successful marketing campaign, allied to a positive and supportive response to initial enquiries, has contributed to a marked increase in the number of adopters being approved. In 2013–14, 123 initial enquiries resulted in 29 new adopter approvals. In 2014–15 the number of enquiries increased to 205, resulting in 41 new adopter approvals. Over half of the adopters spoken to by inspectors said that they had made a conscious choice to adopt through Peterborough, rather than another local authority, because of the welcoming response they received at the time of their initial enquiry.

95. Fostering-to-adopt is well embedded in the care planning process for young babies who need legal permanence, and adopter recruitment processes positively promote it. This is a significant strength as it means that children are able to form attachments with their permanent families at the earliest opportunity. There has been an increase in the number of carers approved to foster to adopt from one in 2013–14 to eight in 2014–15. Four of the eight foster-to-adopt carers have children placed with them.

96. A wide range of family-finding activities, including referral to the National Adoption Register and the use of consortium arrangements, ensures a positive response to children's needs. Inspectors saw good examples of creative marketing strategies, including media campaigns and the use of DVD profiling of individual children. A successful adoption activity day resulted in three children being matched, almost a quarter of the children profiled at that event.

97. The quality of prospective adopter and matching reports is very good. From the assessments seen, inspectors were able to see how prospective adopters would be able to meet the needs of the individual children being matched with them. Good use is made of 'play days' to enable adopters to begin to build relationships with children and help them to familiarise themselves with children's routines, including their likes and dislikes. 'Play days' also offer children the opportunity to start to make a connection with their future parents.

98. A robust adoption panel is actively contributing to improving standards of practice. An experienced and knowledgeable chair has a good overview of the strengths and areas for development of the service and provides regular

updates and feedback to the local authority. Effective quality assurance processes, managed by the adoption panel chair and panel advisor, ensure that reports meet the required standard and are submitted in a timely fashion.

99. The agency decision-makers' decisions are robust, well-evidenced and timely. Their decisions to either accept or overturn panel recommendations are supported by a clear rationale.

100. Adoption support is comprehensive and of good quality. The looked after children psychology service is a particular strength; it offers a wide range of therapeutic interventions, both pre- and post-adoption order. Adopters who have used the service value it highly and report that without it they may have struggled to meet the needs of their child. The adoption support fund is used to fund individualised packages of intervention to support children and families where necessary. All adopters spoken to were aware of their rights to adoption support. In 2014–15, 42 families (56 children) received adoption support and there were over 600 exchanges of letters between birth families and adopters. The local authority currently provides financial support through ongoing adoption allowances to 88 families.

101. Pre- and post-adoption support plans reflect the needs of children and families well and provide a good level of analysis and clear recommendations. For children and families who come back later for support, detailed assessments leading to an appropriate level of intervention clearly demonstrate a needs-led approach. Child in need plans and child and family assessments completed by adoption social workers are of a good standard. In one case seen, where there was a real risk of family breakdown, a comprehensive adoption support package had been put in place.

102. There have been no adoption disruptions in the last 12 months. The quality of adoption placement reports, the rigour of the adoption panel in considering matches and the effectiveness of post-adoption support available are positive.

103. All birth parents and relatives are offered independent counselling and support through a commissioned service which operates on an opt-out basis. Currently, 23 birth relatives are engaged with the service. Referrals are made promptly by social workers. While the large majority of birth relatives receive a service within six months of the referral, this is still a long time to wait. At the time of the inspection 21 birth relatives were waiting for a service. The local authority has supported 23 adopted adults to access their adoption files and receive counselling about their birth records.

104. Life story books are of a high standard. They explain clearly, in a very child-friendly way, why the child was not able to remain with their birth family and include information about children's names, birth families and journey through care. Using a simple template, the books are well-presented and yet highly individualised. There is space for adopted families to continue the child's story and add additional information. The life story coordinator ensures that, where

appropriate, the child's carers and birth families are involved in helping to create the life story book.

The graded judgment about the experience and progress of care leavers is that it requires improvement.

105. The local authority is in touch with 195 of the 198 care leavers identified as being eligible, relevant and former relevant. The local authority's own audits show that the support it provides to care leavers is not yet consistently good.

106. Young people are encouraged not to leave care before they are ready. The local authority has an effective 'staying put' policy that is clear in its commitment to ensuring that young people are able to remain with their carers beyond the age of 18, without financial disadvantage to them or their carers. Currently, 19 (9.6%) care leavers are living with their former foster carers as part of a staying put arrangement where they are supported to develop the resilience and practical skills they need for independent living.

107. The educational achievement and progress of care leavers studying beyond school leaving age are generally good. The vast majority of these young people are studying at the local college. Success rates have improved and are now high. The proportion of children who completed their programmes rose from 82% in 2012/13 to 88% in 2013/14. Of these, 79% went on to do further courses at the college, 18% progressed into employment and 3% into higher education. The local authority currently has seven care leavers at university. They are well supported with financial help above national minimum bursary levels and accommodation is provided during holiday periods for those who are not able to return to their former carers.

108. The local authority has set up a group specifically to work with care leavers who are not in education, employment or training (NEET). It has succeeded in reducing the proportion aged 16–18 who are NEET to 31%. While this is unvalidated data, it suggests good performance, better than national and statistical neighbour rates. The authority's own unpublished data for 2015 show that the proportion of former relevant young people aged 18–21 who are NEET is 37%, significantly better than national (55%) and statistical neighbour (58%) averages.

109. Partnership working is a strength. A range of specific initiatives, such as the establishment of a youth access hub at City College Peterborough and Prince's Trust programmes, also contribute to this success. Plans to develop this work further are ambitious but realistic. One area for development is in the use of apprenticeships. The local authority only has one care leaver on an apprenticeship and there is scope to develop this further. The local authority as the corporate parent misses opportunities as a major employer to significantly boost care leavers' employment prospects by enabling more care leavers to

develop their skills and experience through apprenticeships within the council and with its partners.

110. The authority acknowledges that management supervision needs to be more robust in order to ensure that staff maintain purposeful contact with care leavers and actively drive the implementation of pathway plans.

111. The appointment six months ago of a permanent manager has given the care leavers' team a clearer sense of purpose and direction.

112. There is a mixed response from care leavers to the support provided by social workers and personal assistants. While two young people described their workers as 'amazing', others talked about difficulties in contacting them and of calls not being returned quickly enough. Care leavers also said they would like to be able to contact the care leavers' team without having to disclose their personal details every time they call.

113. Care leavers' needs assessments require improvement; they are not sufficiently detailed, do not consistently identify how the young person's needs will be met and are not routinely updated. This undermines the effectiveness of pathway plans, which also need to be improved. In seven of 11 pathway plans sampled, inspectors found that objectives were not specific enough and plans did not contain sufficient detail in their analysis of children's educational achievements. Some young people spoken to saw pathway plans as of little use. Pathway plans are a key tool in helping to make sure that young people receive the right level of support as they prepare for independence. The local authority needs to do more to engage young people and help them to see and understand the significance and importance of pathway plans.

114. Social workers and personal advisors seek appropriate support for care leavers who are misusing drugs or alcohol. A local foyer provides a good service, which includes a weekly drop-in offering advice and guidance as well as access to confidential sexual health services. One young person talked very positively about the staff and residents. The foyer also employs night-waking staff who monitor the whereabouts of young people in order to ensure they are appropriately safeguarded.

115. The local authority informed inspectors that young people, including care leavers, face significant delays in accessing child and adolescent and adult mental health services. At the time of the inspection there were 365 children and young people on CAMHS' waiting list. However, care leavers who have in the past received a service from the local authority's looked after children psychology service are able to continue to do so beyond their 18th birthday and outcomes from this service are generally good.

116. The local authority does not have an effective way of ensuring that all care leavers receive a summary of their health history. Previously care leavers would have received a 'blue book' but are now just given a copy of their latest health

assessment. This means that, at the point at which they leave care, young people do not have information about their health histories in an easily accessible format.

117. Care leavers told inspectors they feel safe where they are living; nearly all were happy with their accommodation and had been offered a degree of choice in their accommodation. At the time of the inspection, based on the local authority's own data, over 95% of care leavers were in living suitable accommodation, an improvement on the 2014 figure of 84.7%.

118. The local authority has a 'crash bed' which is available on an emergency basis for up to a week. The local authority does not use bed and breakfast (B&B) accommodation and there no care leavers living in homes of multiple occupation (HMOs), except those living at the foyer.

119. Commissioning arrangements with housing providers are effective, with varied and sufficient provision being available to support care leavers. The local authority has an approved provider list; providers are expected to ensure accommodation meets the required standards so that young people are living in safe accommodation with access to support to meet their needs. The local authority has access to 35 foyer rooms. An additional 15 'moving on' flats, available for up to two years, are due to come on stream in May 2015. Housing provision includes accommodation for young parents. Care leavers are afforded the highest priority by the council in providing accommodation to its residents.

120. Housing providers are positive about the working relationship with the local authority and describe the local authority's tendering process as being diligent in ensuring they meet the service specification, are 'safe providers' and are able to improve outcomes for care leavers. Young people receive active support to help maintain their accommodation. Some housing providers have accessed training on child sexual exploitation provided by the Local Safeguarding Children Board (LSCB). Others should be encouraged to attend.

121. The local authority effectively supports care leavers with additional needs through transition to access adult social care services. Some care leavers with additional needs are in transitional 'shared lives arrangements' which help to provide continuity of service. The '0 to 25 years' service, developed partly in response to the needs of care leavers with disabilities, has only been in operation for a short period of time. It is too early to evaluate its impact.

122. Although themed groups are facilitated with care leavers to discuss particular issues and actions taken, the local authority does not have a leaving care forum and none of the care leavers spoken with by inspectors are involved in the Children in Care Council. Young people say they do not feel able to influence the care leavers' service and there is no systematic way of eliciting young people's views when they are receiving or exiting the service. It is too early to assess the impact of the recent use of social media to keep in touch with and consult care leavers.

123. All care leavers are sent a booklet and covering letter which together provide comprehensive information about the support available to them. However, only two out of the eight care leavers spoken to remembered receiving them. This means that not all care leavers understand their rights and entitlements. Young people would have preferred the information to be hand-delivered and explained to them in person.

124. Care leavers have good access to an effective advocacy service. The number of formal complaints about the leaving care service is low. Complaints sampled by inspectors were dealt with appropriately and promptly resolved.

Leadership, management and governance

Key judgement	Judgement grade
Leadership, management and governance	**Requires improvement**

Summary

While action has been taken in response to the recommendations made at the time of the last inspection, progress in improving practice and driving better outcomes for children and young people has been hampered by safeguarding pressures, high turnover of both managers and social workers and a heavy reliance on agency staffing.

A new senior management team is beginning to get to grips with the challenge of improving services. All team and service manager posts have now been filled on a permanent basis. Action is being taken to improve recruitment and retention and ensure that caseloads are manageable across the service. The workforce strategy has been refreshed to attract more permanently appointed social workers. Effective arrangements have been made to support the development of newly appointed social workers. Decision-making and oversight have been strengthened in the MASH and first response teams. While these changes are too recent to have yet made a sustained impact on the quality of practice, staff have welcomed the positive direction being set by the new leadership team. They told inspectors that managers are visible and accessible and that they feel better supported.

Senior managers are making good use of audits to identify strengths and areas for development, although they recognise the need to strengthen performance management systems to enable them to identify and respond quickly to issues of concern. This gap has made it difficult to use service and action plans effectively to drive improvements. For example, the use of separate databases to record information about children missing from home, care and school and those at risk of sexual exploitation makes it difficult to identify links, patterns and trends and to monitor delivery and take-up of return home interviews where children go missing.

Joint working with the police is effective. A major operation to tackle child sexual exploitation has recently led to perpetrators being convicted and their activities disrupted.

Political leaders and senior managers provide a clear vision and there is good evidence of cross-party commitment to children's services. However, the corporate parenting role of elected members is not fully developed and they need to be more challenging and ambitious for children and young people. The Children in Care Council is still relatively new and not yet in a position to exert significant influence on the local authority or reach out to all children in care.

Inspection findings

125. Senior leaders and managers recognise that the local authority has been hindered in driving improvements following the last Ofsted inspection by changes of senior personnel, the challenges of a very large child sexual exploitation investigation and a high turnover of social workers and frontline managers, with a resultant heavy reliance on agency staff.

126. A new, committed and energetic senior management team is beginning to get to grips with the challenge of improving services. They have completed an accurate self-assessment and are pursuing appropriate areas for priority action. As well as appointing a full complement of permanent heads of service and team managers, they have strengthened the MASH by appointing a senior practitioner and invested additional resources in the first response team. Action is being taken to ensure that caseloads are realistic and manageable. A more open and transparent performance culture is being developed, although this is hampered by the limitations of the current performance management information system and the poor quality of some data. Audits are being used to identify strengths and areas for development although service and action plans need to be developed to focus closely on key priorities arising from this audit work. Funding has been secured to reduce waiting times for access to child and adolescent mental health services. There is, however, still a long way to go and it is too early to see the full impact of these changes.

127. The Chief Executive has a clear vision for Peterborough and for children's social care, and was actively involved in planning and implementing the recent restructure, which brought together children's and adults' services in a single People and Communities Directorate. As well as meeting face-to-face with the Director of Children's Services (DCS) once a fortnight, she also chairs the Achieving Outstanding Board (AOB). However, the AOB has not yet had enough impact on, for example, recruitment and retention of social work staff, the timeliness of initial core groups, review child protection conferences and initial health assessments.

128. The Lead Member understands the challenges facing children's social care at both strategic and operational levels. As well as having monthly meetings with the DCS and, separately, with the Service Director Children and Safeguarding and Assistant Director Children's Social Care, the Lead Member regularly meets with social work teams. Once a month, she makes a point of shadowing a visit with a social worker to see and hear first-hand families' experience of children's social care. However, while these activities demonstrate her commitment to acting as a champion for children, they have not had a discernible impact on performance and she acknowledges that there has not been the sustained improvement that is required.

129. There is good evidence of cross-party engagement with, and commitment to, children's services. Against a background of significant cuts in public expenditure, elected members agreed to provide the additional funding needed

to meet budget pressures resulting from the high level of demand on children's social care services, the continuing reliance on agency staff, the cost of independent sector placements and the significant additional expense associated with Operation Erle.

130. There are clear lines of reporting and accountability between the Achieving Outstanding Board, the Health and Wellbeing Board, the Safer Peterborough Partnership Board, the Children and Families' Joint Commissioning Board and the Local Safeguarding Children Board, although it is not easy to understand how their priorities are aligned. A peer review of the Health and Wellbeing Board that was carried out in March 2014 concluded that 'at present the Health and Wellbeing Board is neither a driver of delivery nor a champion of health and wellbeing across the system'. It also found that 'public health is a weak link'. There have been some positive developments since the peer review, with agreement on joint commissioning arrangements, improvements in early help for children with additional needs and a decision by health partners to significantly increase the level of funding for CAMHS. However, inspectors also noted significant gaps for looked after children, with delayed initial health assessments and a lack of focus on mental health and emotional wellbeing in their care plans.

131. The joint strategic needs assessment (JSNA), which was refreshed in January 2015, makes it clear that the health and well-being of children in Peterborough is generally worse than would be expected of an 'average' child in England. Commissioners are making effective use of a mapped model of need to target resources in specific localities. However, the JSNA makes no specific reference to neglect, despite the high number of children in Peterborough who are known to be affected by it. In the absence of a formal neglect strategy, the local authority and its partners do not have a sharp enough focus on this key issue. There is a need to better coordinate this activity across agencies, in order to improve outcomes for the children concerned.

132. Commissioning arrangements are mature, well-developed and effective. Commissioning plans for looked after children reflect changing patterns of need and are delivering a sufficient range of suitable placements, ensuring that the vast majority of looked after children are living with families rather than in residential care. Most children are able to remain at the same schools on their entry to care.

133. Early help services are well established and offer a range of evidence-based programmes for families. In early help, robust service planning arrangements, strong management oversight and a clear focus on outcomes, allied to effective monitoring and evaluation systems, mean that resources are used to best effect to support children and their families. By reinvesting payment-by-results money from the Troubled Families programme into early help services, the local authority has succeeded in increasing capacity and is able to demonstrate improved outcomes for children and families.

134. The elected members' approach to corporate parenting is not sufficiently rigorous and lacks impact. Members of the Children in Care Council have not had a positive experience of the Corporate Parenting Panel. Elected members do not take enough account of children's views and experiences, and are not sufficiently active and challenging on their behalf.

135. The local authority and its partners have had success in tackling the considerable challenge associated with child sexual exploitation. Once children at risk are identified, they are given appropriate help and support. Operation Erle resulted in a number of successful and high-profile prosecutions making Peterborough a safer place for children and families.

136. There are strategies in place to ensure that children who go missing, or are at risk of sexual exploitation, are supported and protected. Managers recognise there is a need to strengthen communication and cross-referencing of data. Currently, separate databases are being used to record information about children missing from home, care and those at risk of child sexual exploitation and those missing from school, making it difficult to identify links, patterns and trends.

137. The independent chair of the LSCB meets regularly with both the Corporate Director and the Chief Executive, and there is evidence of good two- and three-way challenge. The LSCB chair exerts appropriate influence through his membership of the Health and Wellbeing Board, the Achieving Outstanding Board (previously Peterborough's Improvement Board) and the Children and Families Joint Commissioning Board. He carried out a comprehensive, independent test of assurance on the local authority's decision in March 2015 to combine the Director of Children's Services and Director of Adult Services roles. The local authority has implemented his recommendations to mitigate the potential risks by appointing an experienced service director for safeguarding and ensuring that there are separate lead members for children and adults.

138. Senior managers recognise that performance management systems are not sufficiently robust and the high-level performance management reports they receive each month do not allow them to drill down to individual team or social worker level on a real time basis. This inhibits their ability to identify and respond promptly to issues and concerns as they arise and is therefore hampering the drive for improvement. Team managers have to rely on a range of different tracker tools and local databases, the quality and effectiveness of which vary considerably. Throughout the inspection, senior managers had difficulty in responding to basic data requests from inspectors. In some cases the data had to be generated manually. In other cases the figures reported changed several times in a way that called into question the reliability of the data.

139. Senior managers are making good use of audits and independent auditors to identify strengths and areas for development. However, managers are not meeting their targets for the number of cases they audit each month and the quality of service and action plans produced from this work varies considerably. Some are not specific enough about goals, timescales or contingencies and they are not being consistently well used to improve performance and hold individuals to account. Unless priorities are clear and explicit, there is a danger that improvement activity will be diluted.

140. Securing permanent appointments to all team and service manager posts has been an important step forward. Social workers have welcomed the positive direction being set by the new leadership team and told inspectors that they feel better supported by their line managers. However, the quality of supervision that social workers receive is still too variable. Inspectors saw evidence of a lack of challenge, analysis and direction in some supervision records. A lack of consistent management oversight and scrutiny means that some cases remain open for too long and block the flow of work through the system.

141. Complaints made by children and young people are dealt with promptly and sensitively, but managers have not put in place an effective system to ensure staff learn lessons from complaints. Action taken in response to one of the recommendations made at the last inspection means that there are now more opportunities for children to have a meaningful say in the plans and decisions that affect them. High numbers of children and young people are participating in or contributing to their reviews.

142. Leaders recognise that high staff turnover has undermined the quality of practice and some children experience too many changes of social worker. The 24 agency workers in post at the time of the inspection represent 29% of the total staffing establishment. Following a successful recruitment drive, all team manager and service manager posts have now been filled on a permanent basis and the recruitment and retention strategy has been refreshed to attract more permanent applicants, through competitive pay and a clearer career pathway for social workers.

143. The new senior management team is visible to frontline workers and is responding promptly to concerns raised by staff, for example about the capacity of the first response team and the size of caseloads. An amnesty on cases that are stuck or have drifted is encouraging social workers to 'tell it as it is' rather than telling managers what they think they want to hear. Social workers talked to inspectors about feeling better supported in recent months and having a new sense of confidence, security and optimism.

144. The Assessed and Supported Year in Employment (ASYE) programme is effective in providing opportunities for newly qualified social workers to continue their learning and development while holding protected caseloads and being supported by senior practitioners.

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.

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