Kingston upon Hull Safeguarding Children Board

Inspection of the effectiveness of the local safeguarding children board

Inspection date: 18 November – 10 December 2014

Report published: 10 February 2015

The Local Safeguarding Children Board requires improvement
The arrangements in place to evaluate the effectiveness of what is done by the authority and board partners to safeguard and promote the welfare of children *require improvement*.[1]

Contents

[1] A full description of what the inspection judgements mean can be found at the end of this report.

Summary of findings

The HSCB requires improvement because:

Scrutiny and assurance

- The LSCB has not, until recently, provided regular detailed monitoring and evaluation of the effectiveness of practice in all front line services. While it has a long track record of scrutinising work by children's social care services, police and health agencies have not had the same level of oversight or challenge. The LSCB has recognised this and these agencies are now routinely providing data for a multi-agency performance scorecard. However, this is a recent development and its impact is only now becoming evident.
- The LSCB has been slow to develop and coordinate the implementation of its Children Missing and Child Sexual Exploitation strategy. This is now happening and the Board has a clearer view of the nature and extent of risks to children in Hull, but this is not yet comprehensive.
- Board members and constituent agencies have not consistently challenged partners about poor performance or escalated concerns to the Board. This has limited the Board's activity in the execution of its scrutiny function. While the annual report provided by the Board establishes clear priorities and presents an accurate self-assessment, it does not provide a detailed analysis of the impact of its work or the performance of partner agencies.

Learning

- Some frontline workers in partner agencies including children's social care and health could not demonstrate an awareness of learning from serious case reviews and audit activity. While learning has been disseminated, the Board has not effectively evaluated the impact of these lessons on practice.
- While recent engagement with children and young people and their families has improved, the Board has not routinely used their views to inform its work or measure improvement or impact.

What does the LSCB need to improve?

Areas for improvement

Data and performance management

- Ensure that sufficient comprehensive, accurate and timely performance information continue to be provided to the LSCB by all partner agencies and is used to effectively scrutinise performance and assess quality of practice.
- Ensure that the LSCB provides sustained and proactive challenge to partner agencies over safeguarding performance and this leads to improved outcomes for children and young people.
- Ensure that the LSCB annual report provides a rigorous assessment of the performance and effectiveness of safeguarding services and the impact of help and protection on children and young people and their families.
- Ensure that pathways for agencies to escalate concerns to the LSCB are supported by clear evaluation and reporting arrangements.

Practice and policy

- Ensure that arrangements in relation to children missing and children at risk of sexual exploitation are well understood by the LSCB. Ensure that the Board effectively drives this agenda and that action is well coordinated through a clear strategy and action plan and this is reviewed regularly by the Board.
- Ensure that learning from audit activity and serious case reviews is effectively disseminated, learning is evaluated and this work leads to sustained improvements in safeguarding practice.

Quality of practice

- Ensure that the experiences and views of children and young people and their families are identified and used to inform the work of the Board and lead to improvements in safeguarding services.

Summary for children and young people

- Inspectors found that the Local Safeguarding Children Board (LSCB) in Hull needs to improve, although some of its work is helping children and young people.
- The LSCB has not made sure that sufficient people who work with children in Hull know how to identify and help those children and young people who are at risk of sexual exploitation.
- The LSCB does not get enough regular and detailed information from partner agencies about their work. This means that it cannot tell how well they are helping and protecting children, and so cannot identify where improvements need to be made.
- The LSCB has not sufficiently used the opinions of children and their families to help it in carrying out its work.
- The Chair of the LSCB is now making sure that safeguarding improvements for children and young people across Hull are maintained.
- The LSCB provides a lot of training for staff and this has helped to improve services.
- The different agencies of the LSCB work well together and share information and know what services are available to children and families in Hull.

Inspection judgement about the LSCB

1. Governance arrangements between the LSCB and the local authority are effective. The LSCB chair regularly meets with the Director of Children's Services and Chief Executive Officer to ensure that the local authority is fulfilling its safeguarding responsibilities. The Chief Executive holds the chair of the LSCB to account and completes an annual appraisal process.

2. There are clear links between the LSCB and the Health and Wellbeing Board (HWB). The participation of the DCS in both bodies ensures that issues are effectively linked. However, there is little evidence that safeguarding is a key priority for the HWB other than a focus on wider public health concerns such as child obesity and the impact of child poverty.

3. Hull LSCB is chaired by an independent chair, who was appointed in 2010. The Board meets all statutory requirements set out in Working Together 2013. The LSCB receives ongoing commitment and support from local political leaders who retain a clear focus on safeguarding service delivery across the partnership.

4. A revision of the LSCB constitution and assertive action by the Chair has led to improved attendance from more senior key managers and to the appointment of executive leads of sub-committees. The LSCB has clearly identified priorities in the current business plan to improve safeguarding practice. The Board regularly reviews progress and takes any necessary action to meet objectives.

5. In its recently published annual report, the LSCB shows an accurate overview of some of its own strengths and areas for development. For example, it recognises that it does not know enough about the quality of service provision and the difference this makes to the lives of children, young people and families in Hull. It also highlights the need to improve quality assurance and scrutiny of performance information. These shortcomings mean that the LSCB does not have sufficient understanding of the strengths and weaknesses of individual partner agencies. As a result, the annual report does not present a rigorous and transparent analysis of how effectively partner agencies discharge their child protection and safeguarding responsibilities.

6. The LSCB ensures multi-agency policies and procedures are fit for purpose, reviewed effectively and are updated appropriately to incorporate statutory responsibilities and changes to practice. For example, the LSCB has helped to drive forward the implementation of the early help strategy. This has resulted in improved awareness across the partnership of available preventative services.

7. The independent chair is now establishing a culture of scrutiny and challenge across the Board and its constituent agencies. The LSCB now challenges partner agencies' performance through a range of activities including Section 11 audits, case reviews and action plans arising from Serious Case Reviews. This

challenge has resulted in some marked improvements, for example, in relation to understanding about how to manage allegations and the role of the LADO. In response to information about a doubling of CAMHS referral rates in 12 months and significant delays for young people in accessing support and intervention, the LSCB took action that supported the recommissioning of the CAMHS contract. Overall though, it is too soon to know how well these improvements in the LSCB's functioning will be sustained.

8. The lack of performance information available to the Board adversely affects its ability to present a systematic assessment of the quality and effectiveness of safeguarding practice across the partnership. While the LSCB has a clear view of how partnerships operate through audit activity, the Board has not received a consistent flow of performance information in order to identify trends and patterns within individual agencies. Key partners, including health and police have not routinely contributed to a multi agency balanced scorecard. The LSCB has held these agencies to account and is now receiving the data it needs. As a result the LSCB is able to provide a more rigorous examination of the contribution of these agencies. There is early evidence of impact and improvements to practice in some areas as a result of this work. For example, the number of children subject to a child protection plan for a second time has reduced following well targeted intervention. Additionally, the timeliness of child protection visits to children and young people has improved following sustained challenge by the LSCB.

9. In light of the reorganisation of frontline children's social care and the introduction of the "pods", Children's Social Care and the LSCB jointly commissioned a 'strengths-based learning review' to assess whether children continue to receive a responsive and timely service. This identified areas for closer evaluation, such as the timeliness of assessments, quality of planning and high caseloads in social care. The LSCB challenged the local authority about these concerns and as a result senior managers now present regular reports to the Board on these issues. Consultant Social Workers have attended the Board and provided a direct frontline narrative on performance and the challenges they experience. This has been supplemented by a 'walking the floor' visit by Board members to talk directly to frontline social workers

10. Despite a long term strategic and operational joint focus on CSE and missing children, Hull has only recently produced a single multi-agency strategy. The strategy is comprehensive, robust and clear. While the LSCB has completed a multi-agency audit and a self assessment, until recently, work has not been well targeted, coordinated or evaluated effectively. The LSCB identified this shortfall and is now effectively prioritising the CSE agenda and providing sustained drive and focus. As a result, the partnership now has a fuller understanding of the nature and extent of CSE across Hull. While these developments are recent, there are examples of early improvement as a result and it is clear that the Board has strengthened arrangements to monitor risks to children. For

example, recent focus has resulted in the introduction of the MACE risk assessment tool and a review of the definitions of risk document. Additionally, the LSCB has ensured that a significant amount of awareness raising regarding CSE has taken place across the partnership through training and publicity events and this has resulted in a better understanding of the issues of CSE.

11. Partnership work is mostly effective and all key partners are well engaged and make an active contribution to improve the delivery of services for children and young people. Most services are well coordinated and targeted. For example, the LSCB has worked closely with partners to ensure that the Strengthening Families child protection conference model was successfully implemented and secured key agencies' understanding of the model. However, some partners have not effectively escalated concerns appropriately to the LSCB. For example, social workers report delays in gleaning information from the police following child protection concerns. This lack of escalation or challenge on the part of partners reduces the impact of the Board to effectively monitor frontline practice.

12. Partnership working has been further strengthened through the implementation of "Walking the Floor" activities where Board members spend time with frontline practitioners in different settings. For example, Board members from children's social care and youth justice recently met with school nurses, health visitors and nursery nurses. This has facilitated a deeper understanding of services available as well as challenges and strengths within safeguarding services across the partnership.

13. Health, youth justice services and the probation service are fully engaged in the work of the Board at both operational and strategic levels. For example probation challenged health agencies about the availability of services to victims of sexual abuse and as a result a unit at the hospital was maintained to provide support services. The vice chair of the Board is the Head of the National Probation Service (Humberside) and this ensures there is a clear message that safeguarding is seen as everyone's business.

14. The police representative on the Board is a Divisional Commander. This seniority provides an effective high level contribution and swift decision-making and action in response to LSCB findings and challenge. The Chairs of the four Humberside LSCBs meet regularly with the Chief Constable and annually with the Police and Crime Commissioner to ensure most key priorities and challenges are shared and effectively targeted. For example, the LSCB has challenged the police about attendance at review child protection conferences. Additionally the LSCB is currently addressing the fact that Hull does not currently have ready access to secure or secure welfare beds for young people. This has resulted in some young people being held inappropriately in custody overnight. The Board has ensured that representatives from both the voluntary sector and housing providers are actively involved in the Board activity. This effective

communication has resulted in clearer expectations and commitment to safeguarding responsibilities across the partnership. For example, the Council's housing department ensures that their repair and maintenance contractors receive safeguarding training and guidance. Additionally, the LSCB influenced the Children, Young People and Families Board to commission a voluntary and community sector safeguarding support service, which, for example, has established a safeguarding forum and helps ensure that VCS providers receive safeguarding training and know how to make a referral to children's social care.

15. Partnership working between the youth offending service and childrens social care has been strengthened following well targeted work and challenge by the LSCB. Communication and information sharing processes are now well defined and result in effective arrangements to safeguard children and young people. A number of LSCB members now sit on the youth offending management board and this has further strengthened partnership arrangements as well as raised the profile of the youth offending service within the LSCB.

16. Partners make appropriate financial contributions to support the business of the Board. The Board benefits from the membership of one lay member and is actively seeking to appoint a further lay member.

17. While some processes are in place to glean the views of children and young people, these are not systematically collected or evaluated and do not sufficiently inform the work of the LSCB. The Board have identified this as an area for development and in response to this has recently developed a comprehensive programme of events and mechanisms to better engage service users.

18. Since 2012, the LSCB has initiated serious case reviews (SCRs) in response to four serious incidents. In three further cases it decided not to undertake SCRs. The decision in each case was appropriate. Learning is well established and includes lessons from both local and national issues and relevant research. The LSCB disseminates learning across the partnership through training, bulletins and emails. While most practitioners are aware of lessons learnt, a small minority were not. For example, some social workers found it difficult to articulate to inspectors how learning has helped to influence service improvement. Monitoring of whether lessons learnt lead to improvements in practice is not robust.

19. The LSCB undertakes a programme of multi agency audit activity including themed audits on areas such as child sexual exploitation and child protection conference arrangements. This has effectively engaged frontline practitioners their managers, and children and families, so they are directly involved in this learning activity. The quality and impact of audit activity has been variable, but more recent activity has resulted in some well targeted improvements across safeguarding services. While there are clear mechanisms to disseminate key

messages and learning from audit activity, this is not consistently influencing frontline performance or leading to sustained improvements. For example audit activity has identified that detailed risk assessments are not carried out for women with complex social and emotional factors when they first present as pregnant. As a result, potential vulnerabilities are not identified at an early stage. Additionally, health professionals have reported that referrals made by health to social care regarding unborn babies do not always receive a timely response from children's social care services. These shortfalls have been identified and raised by the LSCB but it is too early to see whether significant improvement has ensued.

20. The training strategy supports agencies to identify and address the safeguarding training needs of their workforce on a single and inter-agency basis. The LSCB is committed to commissioning and funding multi- agency safeguarding training and undertakes an annual training needs analysis that informs the delivery of the training programme. This results in clear learning pathways and a comprehensive training programme. Training is well delivered, well received and highly rated by professionals. However, the LSCB has recognised that arrangements to evaluate the impact of training is an area for development and is now taking action accordingly. The training strategy now has a much stronger emphasis on evaluating the impact of learning on practice.

21. Highly effective arrangements for the review of child deaths are in place. The child death overview panel (CDOP) comprises appropriate professionals, is well attended and has clear terms of reference. It reports regularly to the LSCB which also considers the annual CDOP report. Reports identify issues of concern and identified themes, for example, teenage suicides and the risks associated with co-sleeping with infants. Both these issues have resulted in well targeted preventative strategies as well as promoting public awareness across Hull.

Information about the LSCB inspection

This inspection of Hull Safeguarding Children Board was carried out as a joint pilot inspection by Ofsted, the CQC, HMIC, and HMI Probation under section 20 of the Children Act 2004. This inspection replaces the review of the LSCB that would otherwise have been conducted by Ofsted alone under section 15A of the Children Act 2004. Consent to conduct this pilot inspection and publish this joint report was given by the LSCB chair and the statutory Board partners that are members of Hull Safeguarding Children Board.

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This 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 LSCB knows about how well it is performing, how well services in the area are doing and what difference they make for the people they are trying to help, protect and look after.

What the LSCB inspection judgements mean

The grade criteria used for the pilot inspection of the LSCB are listed below. These criteria will be reviewed and may change based on feedback from the participants in this pilot inspection and responses to a consultation on these criteria, run by the inspectorates from June to September 2014.

The LSCB is likely to be judged to be good if the following apply:

- The governance arrangements enable LSCB partners (including the Health and Well-Being Board and the Children's Trust) to assess whether they are fulfilling their statutory responsibilities to help (including early help), protect and care for children and young people. The LSCB effectively prioritises according to local issues and demands and there is evidence of clear improvement priorities identified that are incorporated into a delivery plan to improve outcomes. The LSCB monitors how well partners take forward issues in each agency.
- The DCS works closely with the LSCB Chair and the local authority chief executive holds the LSCB Chair to account for the effectiveness of the LSCB

- Regular and effective monitoring and evaluation of multi-agency front-line practice to safeguard children[2] identify where improvement is required in the quality of practice and services that children, young people and families receive. This includes monitoring the effectiveness of early help.
- The views and experiences of children and young people and their families inform the work of the LSCB. The experiences of children and young people are used as a measure of improvement.
- The LSCB identifies where safeguarding is insufficiently prioritised and takes robust action to challenge and support partners. Partners hold each other to account for their contribution to the safety and protection of children and young people (including children and young people living in the area away from their home authority), facilitated by the chair.
- Safeguarding is a priority for all of the statutory LSCB members and this is demonstrable, such as through effective section 11 audits and section 157 and 175 Education Act Audits. All LSCB partners make a proportionate financial and resource contribution to all LSCB functions, including the audit and scrutiny activity of any sub-groups. The LSCB is sufficiently resourced to meet its statutory functions.
- The LSCB has a local learning and improvement framework with statutory partners. Opportunities for learning are effective and properly engage all partners. Serious case reviews are initiated where the criteria set out in statutory guidance are met and identify good practice to be disseminated and where practice can be improved. They result in shared action plans with clearly defined recommendations for improvement. Serious case reviews are published. The LSCB also uses wider learning from other serious case reviews to improve practice locally.
- The LSCB ensures that high-quality policies and procedures are in place (as required by 'Working together to safeguard children')[3] and that these policies and procedures are monitored and evaluated for their effectiveness and impact and revised where improvements can be made. The LSCB monitors and understands the application of thresholds locally and facilitates a shared understanding across all partners of local thresholds.
- Effective partnership working with other LSCBs within the geographical area ensures a consistency of approach and avoids duplication and/or gaps in policy, systems and processes, where appropriate. Particular attention is given to wider partnerships where board partners relate to more than one LSCB.

[2] This applies to all children and includes having an understanding of the local safeguarding response to deaf and disabled children in all aspects of the LSCB functioning.
[3] Working together to safeguard children, Department for Education, 2013; www.gov.uk/government/publications/working-together-to-safeguard-children

- The LSCB understands the nature and extent of the local issues in relation to children missing and children at risk of sexual exploitation and oversees effective information sharing and a local strategy and action plan.
- The LSCB uses case file audits including joint case audits to identify priorities that will improve multi-agency professional practice with children and families. The chair raises challenges and works with LSCB partners where there are concerns that the improvements are not effective. Practitioners and managers working with families are able to be involved in practice audits, identifying strengths, areas for improvement and lessons to be learned. The LSCB is an active and influential participant in informing the planning of services for children, young people and families in the area and draws on its assessments of the effectiveness of multi-agency practice. It uses its scrutiny role and statutory powers to influence priority setting across other strategic partnerships such as the Health and Well-being Board.
- The LSCB ensures that sufficient, high-quality multi-agency training is available and evaluates its effectiveness and impact on improving front-line practice and the experiences of children, young people, families and carers. All LSCB members support access to the training opportunities in their agencies.
- The LSCB, through its annual report, provides a rigorous and transparent assessment of the performance and effectiveness of local services. It identifies areas of weakness and the causes of those weaknesses, and evaluates and, where necessary, challenges the action being taken. The report includes lessons from management reviews, serious case reviews and child deaths within the reporting period.
- The LSCB effectively scrutinises the performance of custodial and detention facilities within the local authority area.

The LSCB is likely to be outstanding if the following applies:

- In addition to meeting the requirements for a good judgement, it provides evidence of being a highly influential strategic arrangement that directly influences and improves performance in the care and protection of children. That improvement is sustained and extends across multi-disciplinary practice with children, young people and families. Analysis and evaluation of performance is exceptional and helps partners to properly understand the impact of services, the quality of practice and the areas for improvement. There is a comprehensive range of training for managers and practitioners that is directly related to multi-agency improvement priorities. The LSCB creates and fosters an effective learning culture locally that extends to front-line practitioners. The LSCB listens to and understands the views of children and families.

The LSCB is likely to be judged as requires improvement if the following applies:

- It is not yet demonstrating the characteristics of good[4].

The LSCB is likely to be inadequate if the following applies:

- It is not demonstrating that it has effective arrangements in place and the required skills to discharge its statutory functions set out in Working together to safeguard children, the Children Act 2004 and the LSCB regulations 2006. The LSCB does not understand the experiences of children and young people locally and fails to identify where improvements can be made.

[4] Failure to achieve a single criterion will not in itself automatically lead to a judgement of 'requires improvement.' Inspectors will apply 'best fit' and where the inspection team evaluates that good is not the best fit they will evaluate the severity and extent of the weaknesses in practice and the impact on children and young people to determine whether the LSCB 'requires improvement to be good' or is 'inadequate'.

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

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

If you would like a copy of this document in a different format, such as large print or Braille, please telephone 0300 123 4234, or email enquiries@ofsted.gov.uk.

To receive regular email alerts about new publications please visit our website and go to 'Subscribe'.

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