Surrey Safeguarding Children Board

Review of the effectiveness of the Local Safeguarding Children Board

Inspection date: 15 June 2015 – 17 June 2015

Report published: 3 August 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.

Contents

Information about this area[1]

Children living in this area

- Approximately 246,600 children and young people under the age of 18 live in Surrey. This is 22% of the total population in the area.
- Approximately 10% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 9% (the national average is 18%)
  - in secondary schools is 7% (the national average is 15%).
- Children and young people from minority ethnic groups account for 13% 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 and mixed.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 12% (the national average is 18%)
  - in secondary schools is 9% (the national average is 14%).

Child protection in this area

- At 31 March 2014, 4,538 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 5,116 at 31 March 2013.
- At 31 March 2014, 925 children and young people were the subject of a child protection plan. This is an increase from 890 at 31 March 2013.
- At 31 March 2014, 10 children lived in a privately arranged fostering placement. This is an increase from nine at 31 March 2013.
- Between the start of 2012 and the time of the inspection, 18 serious incident notifications had been submitted to Ofsted and 10 serious case reviews had been published.

Children looked after in this area

- At 31 March 2014, 793 children were being looked after by the local authority (a rate of 31 per 10,000 children). This is a reduction from 831 (33 per 10,000 children) at 31 March 2013. Of this number:
  - 344 (or 43%) live outside the local authority area

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

- 76 live in residential children's homes, of whom 32% live out of the authority area
- 22 live in residential special schools,[2] of whom 90% live out of the authority area
- 594 live with foster families, of whom 44% live out of the authority area
- five live with parents, of whom one lives out of the authority area
- 72 are unaccompanied asylum-seeking children.

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

Executive summary

The independent chair of the Local Safeguarding Children Board (LSCB) has been central to the developing authority of the board and to its strengthened focus on key priorities. Progress has accelerated in the last year and brought a growing culture of professional challenge. This has focused particularly on the need for significant improvement in child in need and early help services and on those for children at risk of sexual exploitation or who go missing. Despite this, the LSCB's influence on key bodies such as the Health and Wellbeing Board and Local Family Justice Board, and the independent chair's links with the chief executive of the local authority, are not yet strong enough for the board to achieve the greatest leverage from its scrutiny and challenge role.

The thresholds document 'Early help: multi-agency levels of need' does not meet the requirements of statutory guidance. It does not provide clarity about the types of need that can be met through early help, and those requiring a statutory social work service. This does not help ensure that children get the right service. However, the LSCB has been a champion for improving the quality of work with children in need, young people who go missing and those at risk of sexual exploitation. Its challenge to agencies has been a catalyst for the establishment of a service to provide return home interviews to children who have been missing from care. It has secured an undertaking from the local authority to improve its services for children in need.

The LSCB uses a multi-agency data-set to scrutinise agencies' performance, but it neither analyses the data consistently and fully nor does it link data analysis with audit findings to develop a full understanding of the quality of practice. There has been little success in securing children's views to inform the work of the LSCB.

Decisions about when to initiate a serious case review are sound and learning from such reviews is disseminated effectively. The Child Death Overview Panel considers all deaths in a timely manner, oversees the provision of a valued bereavement service and disseminates public health information on issues such as co-sleeping and head injuries.

The LSCB annual report 2013–14 covers all appropriate areas but lacks rigour in its assessment of the effectiveness of local services. The recently revised 2012–15 business plan, which is informed by the annual report, contains appropriate priorities for 2014–15 but does not include measures to assess progress. It has not been linked with the board's own data-set or learning from audits. Plans to remedy these gaps are in place, with work underway on the 2014–15 annual report and 2015–18 business plan, but these are at too early a stage to have had an impact.

The board provides a broad range of appropriate training. Feedback about its quality is largely positive, but there is no formal evaluation of the long-term impact of training on the quality of practice. This limits the board's ability to understand whether it is providing the right training and how it could best improve its quality and range.

Recommendations

- Update the 'Early help: multi-agency levels of need' document as a matter of urgency, so that it more clearly reflects the expectations of statutory guidance and provides an effective tool to direct and support those who work with children and young people in Surrey (paragraph 4).
- Strengthen the leadership and scrutiny role of the LSCB by developing the strategic statement, action plan and action plan activities so that they better integrate information about child sexual exploitation and children missing from home, care or education, are underpinned by clear impact measures and fully reflect the expectations of current statutory guidance (paragraph 7).
- Improve the existing multi-agency data-set so that it contains a full range of accurate data and enables rigorous analysis and scrutiny of practice; and consider it alongside qualitative information from audits and consultation with children and their families to develop a full picture of quality and effectiveness (paragraph 10).
- Strengthen the relationship of the LSCB with the Health and Wellbeing board and Local Family Justice Board to enable the LSCB to better exercise its 'critical friend' role and help shape the development of services to children and their families (paragraph 2).
- Strengthen the governance arrangements between the chief executive of Surrey County Council and the independent chair of the LSCB so that the chief executive can better hold the independent chair to account for the effective running of the LSCB (paragraph 3).
- Improve the quality and consistency of multi-agency audits so that they can better inform the scrutiny role of the LSCB, priority setting and the content of training courses (paragraph 10).
- Continue the process of developing a 2015–18 business plan that is 'smarter' than the 2012–15 plan and underpinned by clear timescales and impact measures that enable the board to measure progress (paragraph 16).
- Put in place a process for assessing the impact of training on improving the quality of practice (paragraph 15).

Inspection findings

1. The LSCB benefits from the strong leadership of an experienced independent chair who took up post in September 2011, and from effective business management. This has been important in strengthening the coherence and authority of the board. In November 2014 an Ofsted inspection of Surrey County Council's services for children in need of help and protection, children looked after and care leavers found significant failings in the response to children in need and those who go missing or are at risk of sexual exploitation. Since then the board, led by the independent chair and supported by the council's chief executive, has continued to strengthen its challenge and has brought a particular focus on these areas of deficit.

2. Despite this, the board's influence on key partnership agencies is not as strong as it could or should be. Although there is a protocol in place detailing how the LSCB will work with the Health and Wellbeing Board (H&WB), the Children and Young People's Strategic Partnership (C&YPSP) and the Surrey Safeguarding Adults Board (SSAB), it is difficult to see how this has supported the scrutiny and challenge of partner agencies in their development of services for children. Nor is it clear how the board has drawn on the joint strategic needs analysis (JSNA) to inform its work as outlined in statutory guidance. The board is not represented on the Local Family Justice Board (LFJB), and this is a missed opportunity to influence its thinking and approach. When the LSCB does exert influence, it is often issue-specific and reliant on the individual authority of the independent chair, rather than as part of a consistent exercise of the board's role as critical friend.

3. The independent chair and chief executive of the local authority meet formally on a one-to-one basis only twice a year and these meetings are not minuted. There is no annual appraisal by the chief executive of the chair's performance. This makes it difficult for the chief executive to hold the chair to account for the effective running of the LSCB or to benefit fully from her independent view about the quality and effectiveness of services for children provided by the local authority and partner agencies. The lack of strength and formality in the links with the chief executive of the local authority, and the LSCB's relationship with partnership groups such as the H&WB and LFJB, mean there is a risk of loss of impetus when the current independent chair steps down in August 2015.

4. The LSCB thresholds document 'Early help: multi-agency levels of need' (January 2015, interim update published March 2015) does not adequately meet the expectations of statutory guidance. It lacks clarity about the distinction between the needs and characteristics of children and young people who could benefit from early help services and those whose level of need is such that they need help under section 17 of the Children Act 1989. The document brings together both of these groups of children and young people into one category described as a 'Tier 3' level of need. It uses a set of examples of 'Tier 3' levels of need but does not distinguish between those examples that could require early help services and those requiring a statutory social work service. This lack of clarity does not help professionals who may be considering referring a child to children's services, or social workers in making decisions about levels of need and what action to take. The document also lacks guidance on the thresholds for significant harm, care orders and the duty to accommodate a child. It is not clear about early help processes, noting that 'the CAF still has partial acceptance amongst partner agencies', and has not been updated to include clear procedures and processes for cases relating to the sexual exploitation of young people, in line with changes to statutory guidance in April 2015. If professionals who work with children and their families are not provided with a clear, complete and consistent framework for understanding how national legislation and guidance are translated into services at ground level, children and young people are less likely to get the services that best meet their needs.

5. Although the thresholds document is weak, the LSCB has provided strong and consistent scrutiny and challenge to the local authority about the quality of work with children in need, those receiving early help services and the lack of clarity between the two. This challenge is evident throughout 2014 but is clearly stronger in 2015. The publication of the LSCB's early help audit in January 2015 highlighted this and was followed with a meeting of the LSCB in March 2015 at which the local authority provided a report undertaking to strengthen its work with children in need and ensure that it was compliant with legislation and statutory guidance.

6. The LSCB has provided robust scrutiny and challenge about the quality and effectiveness of work by the local authority, police and other agencies with children who may be at risk of child sexual exploitation or who go missing. The well-focused LSCB child sexual exploitation audit, board meeting minutes, the board's challenge log and an extraordinary LSCB meeting in March 2015 all exemplify the strength of this challenge. The LSCB highlighted that children who have been missing were not being offered a return interview by an independent person, as expected by statutory guidance. Such a service is now in place for children who have been missing from care and the board remains tenacious in highlighting the continued absence of such an offer for children who have been missing from home.

7. The LSCB has, through its scrutiny, increased the pace of service improvement for children who are missing or at risk of sexual exploitation. It has ensured a clear governance structure is in place for work in relation to child sexual exploitation, which separates service delivery and operational oversight from monitoring and strategic planning. However, its own strategic statement, action plan and underpinning activities are new (June 2015) and so largely aspirational as yet. These documents do not clearly link consideration of children missing from home, care or education with those at risk of sexual exploitation. They are not supported with a clear plan for assessing progress and do not include the requirement from *Working together to safeguard children* (March 2015) that 'LSCBs should conduct regular assessments on the effectiveness of Board partners' responses to child sexual exploitation'.

8. The LSCB is adequately funded by partner agencies and has negotiated increased funding for 2016–17. This is positive and supports the LSCB's aspiration to enhance its influence on agencies to improve the quality and effectiveness of the services they provide to children. The board is well attended by a full range of partner agencies. It receives regular reports from sub-groups and others, such as the local authority designated officer (LADO), who handles allegations made against adults whose work brings them into contact with children, and MAPPA (multi-agency public protection arrangements), which deal with safety planning in relation to potentially dangerous offenders in the community. When reports are late, such as the recent annual corporate parenting report of May 2015, this is pursued by the board until they are received.

9. The LSCB has an appropriate range of sub-groups. Four area sub-groups keep the work of the LSCB alive across the county and agencies in localities are well engaged. A monthly operational group ensures area boards communicate effectively and deliver consistent messages. The child protection conference dissent and health sub-groups are particularly strong. The child protection conference dissent group provides an effective venue for challenging decision making and planning at conferences to ensure that children have plans that meet their assessed needs and risks. The activity of the health sub-group has led to an increase in the number of safeguarding lead nurses across the county from one to three, driven 100% attendance at level three safeguarding training by general practitioners (GPs) and significantly improved the number of reports from GPs received at child protection conferences from a low base of 20% to a current figure of 47%.

10. A multi-agency data-set is in place to support the LSCB's monitoring and scrutiny role but it requires further development to be fully effective. Work with some partners to provide an analysis and narrative to support their data has not yet been successful. In a more limited number of cases data has either not been provided or is of questionable quality. The quality of analysis and narrative in performance reports to the board is variable and some issues such as poor timeliness of assessments are not commented on. Audit activity takes place routinely and several multi-agency audits have been completed. Audit processes do not adhere to one methodology or format which unnecessarily complicates the task of linking audit findings to performance data. An example of this is that concerns identified in an audit about the effectiveness of child protection core groups are not considered in conjunction with related performance data. Evidence demonstrates that some good quality audit work is undertaken, for example the child sexual exploitation audit, but the reporting of other audits is not sufficiently sharp or analytical. However, despite the variance in quality of reporting, issues of concern are identified clearly. Concerns identified in audit findings are passed to safeguarding leads in the relevant agencies and through area safeguarding boards to ensure appropriate actions are taken. Audits are repeated to test whether actions have had the desired impact.

11. Despite being an area of focus for 2014–15 identified within the 2013–14 annual report, the board has had only limited success in engaging children and young people in shaping its priorities and using their feedback to understand the quality of practice. There has been a small scale audit involving children from nine families who have been through the child protection process but this is an isolated example and it is not clear how the findings have been used. The LSCB has not used mechanisms or organisations such as a children's shadow board, young inspectors, the youth parliament, school councils or the Children in Care Council to engage with children and young people. Although the LSCB has made contact with a representative of the Anglican diocese of Guildford and Portsmouth, it has not been successful in engaging faith organisations in its work. The LSCB has been more successful in its 2014–15 aim to engage with voluntary sector organisations and now has board members from an umbrella organisation for charities working with children and families in Surrey and from two other charities.

12. Processes for making decisions about and undertaking serious case reviews are well established and appropriately overseen by the strategic case review sub-group. This group also monitors and challenges the progress of serious case review action plans. Ten serious case reviews have been published since 2012 in addition to a number of single and multi-agency learning reviews of cases that do not meet the criteria for a serious case review. Current action plans are in the main complete, with only a very small minority of actions outstanding. The process for undertaking reviews is set out in a clear learning and improvement framework. Key principles such as transparency, independence and continuous learning are articulated clearly. The document has not been updated to include changes to statutory guidance from March 2015. Learning from serious case reviews is widely disseminated through e-bulletins, training events, practitioner workshops, sub-group members and the children's services management team. It has directly influenced the shaping of LSCB's escalation policy, which has had a positive impact on practice. A good example of the evaluation of learning is the 2014 deep dive audit of 18 cases conducted by nine health service providers, specifically addressing key messages from serious case reviews. The impact of direct learning from reviews is demonstrated by positive changes to practice within health settings, in particular through a protocol providing procedures and practice guidance for professionals in situations where there is bruising to non-mobile infants.

13. The Child Death Overview Panel (CDOP) is a strong forum with appropriate links with the LSCB. It is sufficiently resourced and works effectively. The panel has made considerable improvement since the appointments of its new chair and specialist nurse for child death reviews. A previous backlog of child deaths requiring review is now cleared and every child death is reviewed soon after it happens. Each family is contacted within 48 hours. A protocol has been agreed with the coroner which supports prompt information-sharing and sample-taking. This means that early case discussions are facilitated and post-mortem findings can be shared with the designated doctor. The specialist nurse provides a valued service to bereaved families where the police are involved, and an updated and accessible child death information booklet and other appropriate booklets are available for families and bereaved children. Learning from CDOP activity, both local and national, is disseminated through the LSCB newsletter, the LSCB operations group, and by email newsletter to all partner agencies. Recent advice and awareness-raising notes have covered safe sleeping, head injuries and fever.

14. In 2014 the LSCB undertook an audit of whether partner agencies were fulfilling their statutory duties to children under section 11 of the Children Act 2004. The LSCB was successful in involving 35 of 37 agencies invited, including 10 out of 11 district and borough councils. The audit, however, lacks analysis and has not involved the LSCB in working alongside agencies or reviewing self-assessments. This limits its impact in improving services for children. To redress this, a number of LSCB workshops to discuss self-assessments with agencies are underway. In addition to this an enhanced approach to section 11 auditing is planned for 2015, although this is yet to have an impact. The LSCB's 2015 audit of schools' compliance with statutory guidance to safeguard children was a significantly stronger process. It was successful in engaging 69% of schools and has received positive feedback. Schools describe the self-assessment process as not just a form-filling exercise but a helpful tool for improving their safeguarding practice.

15. The LSCB provides a broad range of appropriate training within a framework that clearly outlines expectations for those providing either single or multi-agency training. Feedback from participants about training is largely positive. Training courses have been cross-referenced to individual serious case reviews to ensure that the learning from these is reflected in the training provided. This is an effective measure to ensure learning is disseminated to staff from all agencies. However, courses are not cross-referenced with learning from audits and performance information in the same way. For example the learning from three LSCB audits that highlighted poor working practices by professionals involved in child protection core groups has not been used to inform either the volume or content of training provided in this area of practice. This is a missed opportunity. There is no process in place for assessing the medium and long term impact of training on the quality of practice. This makes it difficult for the LSCB to know whether it is providing the right training and how the current training programme should be developed.

16. The LSCB annual report 2013–14, published in September 2014, covers all appropriate areas but is not sufficiently rigorous or transparent in its assessment of the performance and effectiveness of local services. The priorities and challenges identified for 2014–15 within the report are however broadly appropriate and inform a revised and updated 2012–15 business plan. However, this plan is not sufficiently focused and lacks progress measures that would enable the board to evaluate the quality of services. It has not been linked to the board's own audit and performance information. The LSCB is aware of these deficits and aims to remedy them within the 2014–15 annual report and 2015–18 business plan, both of which were in preparation at the time of the review.

17. The LSCB provides a full range of policies and procedures, which are readily accessible to staff from all agencies via its website. These are provided through a contract with a private company and are updated six-monthly to ensure that they remain compliant with statutory guidance and developments in practice. Between updates the LSCB supplements them by adding relevant local and national information to its website to keep practitioners abreast of new expectations. Recent additions to the website have included information on female genital mutilation and the local agency response to the national Prevent agenda.

Information about this review

Inspectors have looked at how successfully the LSCB is achieving its statutory objectives and functions of coordinating and ensuring the effectiveness of how agencies provide services to safeguard and promote the welfare of children. Inspectors have tried to understand what the LSCB knows about how well it is performing and what difference it is making for children, young people and their families. To do this inspectors have looked closely at the work of the board, its structure, policies, procedures and the training it provides to staff from agencies who work with children. Particular attention has been paid to how well the LSCB monitors, scrutinises and challenges agencies and how successfully it keeps children at the heart of all that it does. Inspectors have met with and interviewed not only those employed directly by the LSCB but professionals from across a full range of relevant agencies.

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

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

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