The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is inadequate
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 are inadequate

Summary of findings

The LSCB is inadequate because

Scrutiny and challenge

- Since the last inspection, the pace of improvement has been too slow and resulted in the LSCB not fully discharging its statutory responsibilities. This includes failing to assess the effectiveness of the help being provided to children and families, including early help, and assessing whether LSCB partners are fulfilling their statutory obligations.
- Recent changes made since the appointment of the new independent chair in August 2014 are having a positive impact on the effectiveness of the LSCB.

Performance and quality

- The LSCB has not regularly scrutinised performance information from across agencies.
- The LSCB has not effectively used audits to improve multi-agency practice.

Engagement

- The LSCB has not fully engaged lay members, faith groups or young people in the work of the board.
- The LSCB has not worked with the local Family Justice Board to ensure it scrutinises outcomes for children within the court system.

Learning

- Learning from the LSCB child sexual exploitation (CSE) audit in October 2014 has not been acted upon effectively.
- The LSCB has not consistently ensured that learning from local serious case reviews has been implemented across all partner agencies to help improve practice.
- The quality and impact of training has not been adequately evaluated by the LSCB, despite this concern being noted within the 2013–14 annual report.

What does the LSCB need to improve?

Priority and immediate action

Scrutiny and challenge

154. Ensure that partners, both as individual agencies and within statutory partnerships are scrutinised and held to account for the quality and impact of their practice with children and families.

155. Ensure that a S11 audit takes place so that the LSCB can assure itself partners are fulfilling their statutory safeguarding duties.

156. Scrutinise the understanding and application by partner agencies of the LSCB threshold document in order that all children and young are receiving services appropriate to their needs.

157. Oversee the gathering of intelligence of CSE to inform training and planning so that agencies fully understand their roles in identifying concerns for children who are at risk of CSE.

Learning and development

158. Ensure that learning from case file audits, local serious case reviews, learning reviews and key national serious case reviews is routinely disseminated across partner agencies, that it is used to inform the development of policies and procedures and that learning and recommendations from action plans have been implemented.

Areas for improvement

Performance and quality

159. Implement the new multi-agency data set and quality assurance framework to ensure that the LSCB has a clear understanding of the performance of agencies and the findings from audit. Scrutinise partners' use of audits in driving improvement.

Engagement

160. Ensure that children and young people are able to influence the work of the LSCB and that the wider community is involved through ensuring that the Board has active lay members and engages with faith groups.

Learning

161. Use the new learning and improvement framework to ensure that the quality and impact of training is assessed and that training available clearly reflects priorities identified by the LSCB.

Inspection judgement about the LSCB

162. The LSCB has not demonstrated that it is effectively discharging its statutory functions. Progress by the LSCB has been too slow since the time of the last Ofsted inspection when an area for development was to improve the functioning of the LSCB. Although progress since the appointment of a new independent chair has been rapid, it is too recent and at too early a stage to have had a significant impact on the Board's ability to fulfil its statutory functions.

163. The new chair's review of the functioning of the LSCB presented to the performance accountability board (PAB) in October 2014, concluded that at that point in time the LSCB was not discharging its statutory responsibilities. The review highlighted similar concerns to those raised by the chair of the PAB and by the DfE during 2014. These concerns included not assessing whether partners are discharging their statutory functions; not prioritising key safeguarding issues or incorporating them into a delivery plan; and limited auditing that does not identify where improvement is needed. It also identified an underdeveloped learning and improvement framework, partners not holding one another to account, not assessing or challenging the effectiveness of local services and not using its scrutiny role effectively to challenge statutory partnerships such as the Health and Wellbeing Board (H&WB). Governance arrangements are now in place and the Chief Executive holds the chair to account through regular meetings and through reporting to the PAB.

164. LSCB board members from partner agencies, state that until recently the board was drifting and had no clear direction. The new chair has brought leadership and purpose to the work of the board, although impact has yet to be demonstrated.

165. The LSCB arrangements for scrutinising the performance of agencies in a structured manner with the use of a broad data set of performance information have been ineffective. This important function has largely been left to the PAB and has limited the LSCB's ability to assess the effectiveness of help being provided to children and their families. Although the LSCB is planning to carry out a Section 11 Audit during 2015-16 to assess whether agencies are fulfilling their statutory obligations as set out in chapter two of Working Together 2013, it has not carried out such an audit in 2014-15. This compounds its failure to monitor, scrutinise and provide leadership to agencies who provide services to safeguard children. Although the Board's new performance framework and dataset are too new to have had an impact yet, they are important documents that, alongside an improving culture of challenge, mean that the LSCB is now much better placed to take on this monitoring and scrutiny function in the near future.

166. The role of case file audits to help the board scrutinise, understand and drive up the quality of practice with children their families is underdeveloped. For example, although the July 2014, Section 31 threshold audit identified delay within three of five cases looked at, it is not possible to see how this learning has been applied to practice and impact assessed by the LSCB. None of the five actions on a 'voice of the child' audit action plan from April 2014 has been concluded.

167. The influence and involvement of children and young people with the work of the LSCB is underdeveloped as is engagement with the faith community, an important consideration in an area of cultural, ethnic and religious diversity. The board has not benefited from regular attendance by lay members; this also limits its ability to engage with the wider community and act as an influential advocate for children's safeguarding.

168. The LSCB's 'threshold document' is supported by a full package of training. However, in relation to how thresholds are applied in practice the LSCB has not assured itself that the learning from audits, is being used to ensure that they are consistently and correctly applied and that children are receiving the services they need. This is a serious gap in the LSCB's scrutiny of front-line practice.

169. The LSCB has not assured itself that children at risk of CSE in Sandwell are identified by agencies or that they are receiving appropriate services. It has not provided sufficiently timely or strong leadership despite having a longstanding link to the Young People at risk of Sexual Exploitation and Missing group (YPSEM). The LSCB is in the process of revising and updating its CSE strategy, but this work is not yet complete.

170. An audit of five cases of children and young people at risk of CSE presented to the Board in October 2014, resulted in the roll out of a CSE screening tool by the local authority and provided impetus to plans for the new CSE team. However, four months on from these audits the LSCB has not been assured that recommendations have been carried out so that young people are effectively safeguarded.

171. The Serious Case Review sub-group has undertaken learning and serious case reviews but has not ensured that learning from these or from key national serious case reviews is routinely disseminated to staff across agencies, or that it informs the training programme or the development of policies and procedures. Although recently collated into an over-arching action plan, recommendations from these reviews have not been tracked for completion and to assess impact on practice. Learning has been disseminated to professionals and managers directly involved in cases reviewed. There has also been training of some specific staff groups such as housing officers and health visitors, but learning has not been cascaded across agencies in a co-ordinated way. Two planned events to share learning more widely were cancelled recently due to a lack of capacity to deliver them.

172. The LSCB provides a range of core training which was well attended during 2013-14. However, evaluation of the quality and impact of this training has been limited. This is noted within the LSCB 2013-14 annual report. Until the recent publication of a new Learning and Improvement Framework, there has been no clear mechanism for addressing this area for development in a structured manner.

173. The LSCB annual report dated November 2014 was prepared in parallel with the new chair's strategic review report. The annual report identifies, but does not fully explore, some deficits in both the running of the board and in agency practice. This includes the failure of the policy and procedures sub-group to meet for 18 months and a failure to identify what the board is doing to scrutinise private fostering practice. It does however provide detailed information on the work of some subgroups, such as the Child Death Overview Panel (CDOP). This group, although without a co-ordinator for some months last year, is an established and active group that has developed a range of public health campaigns from through its work, including safer sleeping and suicide prevention.

174. A broad range of partners attend LSCB board meetings from relevant agencies and, following the recent review of the board's functioning, the LSCB has a new structure including a number of appropriate sub-groups. Board members report that the chairs group, made up of the chairs of the sub-groups, now acts in a co-ordinating role and drives the work of the Board.

175. Engagement with schools has been strengthened through a new clearer structure to engage representatives of schools (primary, secondary, colleges and special) and a strengthened approach to S.175 audits providing greater challenge to schools.

176. There has also been challenge to agencies in relation to their willingness to carry out the 'lead professional role' within Team Around the Family meetings (TAFSs) and challenge to West Midlands police at the December Board in relation to their practice with missing children following a recent inspection by Her Majesty's Inspectorate of Constabulary (HMIC).

177. From a low base, the work of the LSCB is now going through a necessary and rapid period of development. This is based on a new 2014-15, 10 point business plan presented to the Board in October 2014. This stemmed from the strategic review and is aimed at moving the Board to a position where it is able to fully discharge its statutory functions within six months. A workshop event for Board members on 15 January 2015 considered how to make this vision a reality. This provides a clear route map for progress but it remains too soon for a significant impact to be seen.

178. The LSCB chair attends the Health and Wellbeing Board (H&WB) and a new document shaped by the chair lays out the roles of LSCB, the local safeguarding adults' board, the H&WB and the Safer Sandwell Partnership. This will support the LSCB in the exercise of scrutiny of other statutory partnerships in the future and will assist the LSCB in taking the lead role in providing inter-agency monitoring challenge and leadership.

What the inspection judgements mean

The local authority

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

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

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

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

The LSCB

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

An LSCB that is **good** coordinates the activity of statutory partners and monitors the effectiveness of local arrangements. Multi-agency training in the protection and care of children is effective and evaluated regularly for impact. The LSCB provides robust and rigorous evaluation and analysis of local performance that identifies areas for improvement and influences the planning and delivery of high-quality services.

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

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

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 professionals 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 seven of Her Majesty's Inspectors (HMI) from Ofsted.

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