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Dear Ms Redding

Focused visit to Peterborough children's services

This letter summarises the findings of the focused visit to Peterborough children's services on 1 to 2 March 2023. His Majesty's Inspectors for this visit were Tracey Ledder and Kathryn Grindrod.

Inspectors looked at the local authority's arrangements for the front door.

This visit was carried out in line with the inspection of local authority children's services (ILACS) framework.

Headline findings

The arrangements to identify and respond to concerns raised regarding the safeguarding and well-being of children in Peterborough are not effectively promoting the protection of children. Risks and needs are not fully understood or responded to in a timely way. As a result, children's needs are not being identified and addressed swiftly enough.

Areas for priority action

- The timeliness of response to contacts, referrals and multi-agency safeguarding hub (MASH) enquiries about children and subsequent visits from social workers.

- Multi-agency arrangements and responses to children and young people at risk of extra-familial harm.

What needs to improve in this area of social work practice?

- Operational management of the front door so that the necessary changes and improvements are delivered robustly and at pace.

- Quality assurance processes, including auditing, as well as direction by managers.

- The quality of supervision.
- The reliability of the online referral process so leaders can be assured that referrals are not lost.
- Ensuring that children's experiences and the impact are understood, and their voice is reflected in all social work interventions.

Main findings

The senior leadership team has significantly changed in Peterborough in recent months. The new interim director of children's services, who took up her post in November 2022, quickly identified some significant, systemic practice concerns, including weaknesses at the front door.

The members of the interim senior leadership team are getting to grips with some of the many shortfalls in practice that they have identified. They have completed deep dives into practice, which highlighted the accumulative lack of systemic oversight of the various front door arrangements. This helped them understand practice and develop action plans. Senior leaders have started to implement the plans. Some early improvements can be seen. However, senior leaders continue to identify further areas of practice that need improvement. In addition, change does not always happen quickly enough.

Senior leaders are delivering change in a child-focused way that staff understand. Staff are positive about changes to practice, and they are committed to delivering better services for children. Staff are optimistic about the future and morale is high.

Recent changes made at the integrated front door (IFD) have improved the social work oversight of initial decision-making. However, too many children in Peterborough still do not receive a prompt and timely response when concerns are raised about their welfare.

Referrals made online by partner agencies do not always arrive at the contact centre. Inspectors highlighted this during this visit. Staff had failed to escalate this to allow prompt investigation of the issues, and this delayed the response to those children who were potentially at risk. Senior leaders acted when inspectors made them aware of this issue.

Immediate and obvious risks to children and unborn babies are quickly recognised. Those children are allocated a social worker to progress the case.

When children are not deemed to be at immediate and obvious risk, responses are not timely enough for too many children. This is because there are initial delays between the contact centre and IFD, both before and after oversight of contacts. Once the contact is progressed, there are too many delays in commencing and concluding multi-agency safeguarding hub (MASH) enquiries. This delays important decisions being made about children.

Parental consent required to complete MASH checks, is mostly appropriately sought or dispensed with. Checks from other agencies are requested proportionately. Prior to March 2023, health checks were not routinely completed due to capacity issues. To remove inherent risk, senior leaders made the decision to progress these children for a social work assessment. Changes implemented at the start of March 2023 mean that health checks are now completed, they are thorough, and they are helpful for informing decision-making for children.

When MASH checks are completed, they are usually thorough and informative. There is often a lack of urgency by social workers collating the multi-agency information. This means that for some children who need a social work service, there are further delays. Workers sometimes show a lack of curiosity about children's lives and do not consider the presenting risks quickly enough. The safety of children during the completion of checks is not always confirmed by workers in IFD. This means that children are left in situations of potential risk for too long.

Oversight by senior practitioners is routine for all MASH enquiries. However, this is variable in quality. In stronger examples, direction to workers is clear and captures areas of risk and need well. In weaker examples, their guidance does not identify all the relevant areas of risk or concern. In addition, there are no clear or directive actions. Records do not capture or reflect the impact for children.

For a small number of children who have been the subject of repeated concerns, opportunities to intervene are not always taken at the earliest opportunity. This creates delay in some children and families receiving the support they need.

Once the decision is made that children require statutory services, there is delay for some children in this work being picked up by assessment teams. This puts pressure on those social workers to try and see children in a timely way. This is not always achieved.

Child protection strategy meetings usually happen at the right time. There have been delays due to the capacity of partner agencies. Meetings involve the right professionals. Information that is shared is mostly relevant and helpful. This ensures that risks are clearly identified. Actions agreed at strategy meetings do not always address all of the presenting issues, for example contingency arrangements if risks remain. This means professionals are unsure how to respond to changes in circumstances. Child protection enquiries are completed promptly. They identify risks to children and reach appropriate conclusions about next steps.

Responses to exploitation of children and to extra-familial harm are not effective. The local authority and partner agencies have been aware of this shortfall for too long without taking effective action. The recent deep dive and the subsequent action plan undertaken by the local authority are a helpful starting point to ensuring that the shortfalls are understood. However, the pace of change is too slow. This means that that risks for children are not understood, managed or reduced.

The current arrangements do not ensure that all children who are vulnerable to exploitation and abuse are effectively identified and protected by services which are delivered in a coordinated and informed way. This is compounded by a lack of joint and integrated working and collaboration, which hinders agencies from understanding and responding to risk. As a result, some children are left in situations of risk.

The current multi-agency child exploitation arrangements (MACE) are not effective. Meetings achieve little in understanding, managing and reducing risks. Actions from MACE meetings are not clear enough. Actions remain on the agenda for too long, with no evidence of challenge from members of MACE in respect of drift and delay. It is difficult to understand actions for individual children. When children are discussed at MACE, records are weak, they lack detail of the concerns and do not provide actions to help reduce and manage risks for them. In addition, records are not shared effectively with children's social workers and other professionals working with the children discussed so as to help keep children safe.

There is a lack of understanding of contextual safeguarding across all agencies. Some children who are victims of exploitation continue to be criminalised, and insufficient attempts are made to meet their needs or prevent them from being criminalised. Social workers and managers fail to recognise and challenge this. There is a lack of professional curiosity when children present with indicators of exploitation. Because of this, opportunities are missed to provide help and support and reduce risk.

The arrangements in place to track and monitor children who go missing from care or return from being missing from care are mostly effective. Daily reviews of information alongside a police colleague are helpful. These meetings ensure that any children who have gone missing from care or have returned overnight are identified and contacted. Mostly, return home interviews carried out with children are timely. The arrangements ensure that children are referred into children's social care if concerns increase. There is clear guidance in respect of when a strategy meeting should take place and evidence that this happens. The missing processes are not integrated into wider safeguarding arrangements. This prevents a collaborated and joined up approach to safeguarding children.

The current arrangements in respect of quality assurance are not effective. There is not enough emphasis and focus on children's experiences or the impact of social work intervention. Quality assurance activity focuses on processes and compliance and does not facilitate learning and development. For example, children's audits are not based on a sound understanding of good practice standards. The process fails to help social workers understand what they need to do to improve children's situations.

Workers in the MASH and assessment teams feel well supported in Peterborough. They talk of manageable workloads and easy access to colleagues and managers to seek advice and guidance. Managers provide regular supervision. However, the quality of supervision is variable. At times, managers do not identify all areas of risk or need. Not all supervision records show reflection and challenge, and process is prioritised over understanding the child's journey.

Ofsted will take the findings from this focused visit into account when planning the next inspection or visit.

We have notified the Department for Education of the areas for priority action. You should submit an action plan that responds to these areas within 70 working days of receiving this letter. It would be very helpful if you can share an early draft of the action plan with us within 20 working days of receiving this letter.

Yours sincerely

Tracey Ledder
His Majesty's Inspector