

Safeguarding Children Briefing



THE PROTECTION OF CHILDREN IN ENGLAND: A PROGRESS REPORT

BACKGROUND

In November 2008 the Secretary of State for Children, Schools and Families (DCSF) commissioned Lord Laming, who had previously chaired the inquiry into the death of Victoria Climbié, to undertake an independent progress report on child protection in England following the tragic death of Baby P in the London Borough of Haringey.

INTRODUCTION

This review was to look at what good practice had been achieved in safeguarding since the Victoria Climbié Inquiry Report, what key barriers existed which prevented efficient and effective safeguarding and what actions should be taken by Government and local agencies. His report, *The Protection of Children in England: A Progress Report* was published on the 12th March 2009.

The progress report aims to: evaluate the good practice that has been developed since the publication of the report of the Independent Statutory Inquiry following the death of Victoria Climbié; identify the barriers that are now preventing good practice becoming standard practice; and recommend actions to be taken to make systematic improvements in safeguarding children across the country.

The review stresses the need for professionals to take responsibility for the safety of the children they deal with in their work: *"Every professional coming into contact with a child in whatever context should be clear that it is not acceptable to do nothing when a child may be in need of help"*. It stresses that, *"Vulnerable children and families have a right to expect that the services they are provided with are based on evidence that they have been shown to work in meeting their needs"*.

THE FINDINGS

The report has 58 recommendations on how to protect children from harm. These include:

■ **National Safeguarding Delivery Unit (NSDU)**

Lord Laming recommends that the protection of children must be a higher strategic priority across all frontline services, but recognises that integration of services and joined-up working at a local level is made even more difficult without realisation of the same goals in central government. To address this imbalance, Lord Laming recommends that DCSF, the Department of Health, Home Office and Ministry of Justice collaborate on the national level through a National Safeguarding Delivery Unit, accountable to Parliament, to inject drive into the implementation of change and to support local improvement.

With an initial remit for three years, the NSDU will draw upon expertise from practising senior staff with frontline experience in safeguarding across children's services, police, health and other partners. This Unit will:

- commission training on child protection and safeguarding for political leaders and service managers
- oversee the implementation of the recommendations from Lord Laming's report
- support Children's Trusts to implement the recommendations
- raise the profile of safeguarding and child protection across all partners
- work with partners to create a shared evidence base about best practice in early intervention and preventative-services
- commission training on child protection and safeguarding for political leaders and service managers

- **Ofsted should revise the inspection and improvement regime for schools giving greater prominence to how well schools are fulfilling their responsibilities for child protection.** *"Schools and early years settings need to be encouraged to prioritise safeguarding children within their school improvement plans. The inspection and improvement regime for schools needs to ensure that schools are proactively involved in safeguarding children, for example by offering multi-agency services on-site, making sure that their staff understand the referral arrangements in their area, and by continuing involvement in supporting children by attending child protection conferences and sharing information where appropriate. This is crucial in keeping children safe and often in keeping them in education."*

- **A national strategy to address recruitment and retention problems in children's social work**

- **The introduction of targets for child protection, similar to school targets**

- **National guidelines setting out maximum case loads for social workers** *"Every Child Matters is intended to organise services and resources around children to ensure their safety and proper development, and improve their well-being. However, there are significant levels of concern that current practice, and in particular the pressure of high case-loads for children's social workers and health visitors, has meant that staff often do not have the time needed to maintain effective contact with children, young people and their families in order to achieve positive outcomes."*

- **Children's Trusts must ensure that all assessments of need for children and their families include evidence from all the professionals involved in their lives, take account of case histories and significant events (including previous assessments) and above all must include direct contact with the child.** *"Fundamental to establishing the extent of a child's*

need is a child centred, sensitive and comprehensive assessment. Assessment should involve gathering a full understanding of what is happening to a child in the context of their family circumstances and the wider community, using a variety of sources of information. It must, therefore, be a joint or parallel assessment with all professionals concerned for the child's safety and welfare."

- **The Department for Children, Schools and Families should revise *Working Together to Safeguard Children* to set out clear expectations at all points where concerns about a child's safety are received, ensuring intake/duty teams have sufficient training and expertise to take referrals and that staff have immediate, on-site support available from an experienced social worker.**

"A key factor in identifying children and young people who need help is ensuring services are designed to encourage contact from members of the public, parents and children and young people as well as by other agencies. If safeguarding children is everybody's responsibility, then everybody should know how, and who, to contact if they are concerned about a child or young person."

- **A consideration of the abolishment of court fees for care proceedings**
The introduction of such fees meant that fewer children were put into care who may have been safer if this had happened. Laming highlights the concerns over the increase in fees for care applications introduced in 2008 and concludes that, "it may well be that abolition of fees altogether in these cases would be the safest course. For this reason, the Ministry of Justice should undertake to hold an independent review of the impact of the fees in the coming months. Unless this review provides incontrovertible evidence that the fees were not acting as a deterrent, the fees should then be abolished for the financial year 2010/11 and the ensuing years, with the funding transferred from the local government settlement to the Ministry of Justice."

- **A common language and understanding across professionals**
"All Children's Trusts should have sufficient multi-agency training in place to create a shared language and understanding of local referral procedures, assessment, information sharing and decision making across early years, schools, youth services, health, police and other services who work to protect children. A named child protection lead in each setting should receive this training."

- **..core group meetings, reviews and casework decisions (should) include all the professionals involved with the child, particularly police, health, youth services and education colleagues. Records must be kept which must include the written views of those who cannot make such meetings.**
"It is clear that most staff in social work, youth work, education, police, health and other frontline services are committed to the principle of interagency working, and recognise that children can only be protected effectively when all agencies pool information, expertise and resources so that a full picture of the child's life is better understood. Cooperative working is increasingly becoming the normal way of working. However, good examples of joint working too often rely on the goodwill of individuals. Colleagues in education, early years, health and police are vital partners in protecting children and they need to be willing and proactive in discharging their statutory duty to cooperate on child safeguarding."

- **Increased quality of degrees in social work and the introduction of a children's social worker post-graduate qualification**

- All police, probation, adult mental health and adult drug and alcohol services should **understand referral processes**.

■ **Serious Case Reviews**

These should include consideration of lessons to be learned within each service involved and in terms of co-operation. Working Together should be amended to be explicit about this objective for SCRs and to ensure that SCRs focus on learning lessons and implementing recommendations. DCSF should revise SCR framework to ensure panel chairs have access to all relevant documents. Ofsted should focus its evaluation of SCRs on the depth of learning a review has provided and the quality of its recommendations.

SCRs depend on confidentiality. Full reports should remain confidential, although shared with agencies and Inspectorates. High quality publicly available executive summaries must accurately reflect the full report, contain the full action plan and include the names of SCR Panel members. Working Together should be amended to reflect this.

Further guidance is needed on when to conduct an SCR. SCR Panel chairs must be independent of all local agencies involved. SCR report authors (possibly the Panel chair) must be independent of agencies involved. National training should be available for SCR Panel chairs and report authors and government should take the lead in ensuring sufficient trained people available.

■ **Local Safeguarding Children Board**

LSCBs are having a positive impact on services. Research from Loughborough University on structures and working arrangements of LSCBS – interim findings due spring 2009. DCSF should provide further guidance following this research.

Clear distinction needed between roles and responsibilities of LSCBs and Children's Trusts. Same person should not chair both. Independent chairs must be experienced in statutory safeguarding and child protection services and have access to training and support. LSCB should include senior decision makers from all safeguarding partners who should attend regularly and be fully involved.

Children's Trust is responsible for improving children's well-being including keeping children safe. LSCB ensures multi-agency partners co-operate to safeguard and promote children's welfare. LSCB should report to Children's Trust on effectiveness of safeguarding and improving welfare. LSCB should provide a robust challenge to the work of the Children's Trust.

GOVERNMENT RESPONSE

All the report's recommendations were accepted in their entirety by Children's Secretary, Ed Balls. The Government will set out detailed responses before the end of April.

■ Ed Balls announced the immediate appointment of Barnardo's head Sir Roger Singleton into a new post of chief government adviser on the safety of children. Singleton will drive a new cross-government National Safeguarding Delivery Unit (NSDC) which will support and challenge every local authority and every children's trust in the country as they carry out their responsibilities to keep children safe. Sir Roger Singleton will report annually to Parliament on safeguarding children.

■ Independence and quality of SCRs to be strengthened – NSDU to monitor.

- Every local authority to have statutory Children's Trust Board.
- LSCB to be effective local watchdogs to hold Children's Trust and local agencies to account.
- **Revised statutory guidance will set out**
 - presumption that all LSCBs have an independent Chair;
 - DCS and Lead Member to be members of both Children's Trust Board and LSCB;
 - the relationship between children's trusts and LSCBs
 - Chief Executive and Council Leader to confirm annually that their arrangements comply with the law;
 - Two members of the general public to be appointed to every LSCB.
- Social Work Training Taskforce to take forward recommendations on training and development. Already reviewing effectiveness of ICS – to report in April.
- Starting this year:
 - newly qualified social workers to receive a year of intensive induction training, supervision and support;
 - Advanced Social Work Professional status to ensure most highly skilled practitioners stay close to the frontline with better career progression;
 - Graduate recruitment scheme to be expanded and qualified workers to be attracted back to the profession;
 - Over time, all practitioners to be able to study on the job for Masters level qualification.
- The Leadership College will expand its remit, introduce a leadership programme for DCSs from September and create an accelerated learning programme for future leaders.
- Health Secretary announcing that the chief nursing officer will lead a programme of action on health visiting. This programme will be developed and delivered in partnership with the Community Practitioner Health Visitor Association, other key stakeholders and NHS experts across the country. "It will ensure the key roles of health visitors are defined and delivered, that health visitors are supported in their vital work and that career opportunities and numbers of health visitors are increased."
- Home Secretary implementing recommendations to improve skills and capacity of police in child protection.
- Justice Secretary appointed Francis Plowden to review court fees and if there is evidence that they are a barrier to local authorities contemplating care proceedings, fees will be abolished.

COMPLETE LIST OF RECOMMENDATION

1. The Home Secretary and the Secretaries of State for Children, Schools and Families, Health, and Justice must collaborate in the setting of explicit strategic priorities for the protection of children and young people and reflect these in the priorities of frontline services.
2. A National Safeguarding Delivery Unit be established to report directly to the Cabinet Sub-Committee on Families, Children and Young People. It should have a remit that includes:
 - working with the Cabinet Sub-Committee on Families, Children and Young People to set and publish challenging timescales for the implementation of recommendations in this report;
 - challenging and supporting every Children's Trust in the country to implement recommendations within the agreed timescales, ensuring improvements are made in leadership, staffing, training, supervision and practice across all services;
 - raising the profile of safeguarding and child protection across children's services, health and police;
 - supporting the development of effective national priorities on safeguarding for all frontline services, and the development of local performance management to drive these priorities;
 - leading a change in culture across frontline services that enables them to work more effectively to protect children;
 - having regional representation with expertise on safeguarding and child protection that builds supportive advisory relationships with Children's Trusts to drive improved outcomes for children and young people;
 - working with existing organisations to create a shared evidence base about effective practice including evidence-based programmes, early intervention and preventative services;
 - supporting the implementation of the recommendations of Serious Case Reviews in partnership with Government Offices and Ofsted, and put in place systems to learn the lessons at local, regional and national level;
 - gathering best practice on referral and assessment systems for children affected by domestic violence, adult mental health problems, and drugs and alcohol misuse, and provide advice to local authorities, health and police on implementing robust arrangements nationally; and
 - commissioning training on child protection and safeguarding and on leading these services effectively for all senior political leaders and service managers across those frontline services responsible for safeguarding and child protection.

Leadership and accountability

3. The Cabinet Sub-Committee on Families, Children and Young People should ensure that all government departments that impact on the safety of children take action to create a comprehensive approach to children through national strategies, the organisation of their central services, and the models they promote for the delivery of local services. This work should focus initially on changes to improve the child-focus of services delivered by the Department of Health, Ministry of Justice and Home Office.

4. The Government should introduce new statutory targets for safeguarding and child protection alongside the existing statutory attainment and early years targets as quickly as possible. The National Indicator Set should be revised with new national indicators for safeguarding and child protection developed for inclusion in Local Area Agreements for the next Comprehensive Spending Review.
5. The Department of Health must clarify and strengthen the responsibilities of Strategic Health Authorities for the performance management of Primary Care Trusts on safeguarding and child protection. Formalised and explicit performance indicators should be introduced for Primary Care Trusts.
25. Directors of Children's Services, Chief Executives of Primary Care Trusts, Police Area Commanders and other senior service managers must regularly review all points of referral where concerns about a child's safety are received to ensure they are sound in terms of the quality of risk assessments, decision making, onward referrals and multi-agency working.
26. All Directors of Children's Services who do not have direct experience or background in safeguarding and child protection must appoint a senior manager within their team with the necessary skills and experience.
27. The Department for Children, Schools and Families should organise regular training on safeguarding and child protection and on effective leadership for all senior political leaders and managers across frontline services.
28. Every Children's Trust should ensure that the needs assessment that informs their Children and Young People's Plan regularly reviews the needs of all children and young people in their area, paying particular attention to the general need of children and those in need of protection. The National Safeguarding Delivery Unit should support Children's Trusts with this work. Government Offices should specifically monitor and challenge Children's Trusts on the quality of this analysis.

Support for Children

29. Ofsted should revise the inspection and improvement regime for schools giving greater prominence to how well schools are fulfilling their responsibilities for child protection.
30. The Department for Children, Schools and Families should revise Working Together to Safeguard Children to set out clear expectations at all points where concerns about a child's safety are received, ensuring intake/duty teams have sufficient training and expertise to take referrals and that staff have immediate, on-site support available from an experienced social worker. Local authorities should take appropriate action to implement these changes.
31. The Department of Health and the Department for Children, Schools and Families must strengthen current guidance and put in place the systems and training so that staff in Accident and Emergency departments are able to tell if a child has recently presented at any Accident and Emergency department and if a child is the subject of a Child Protection Plan. If there is any cause for concern, staff must act accordingly, contacting other professionals, conducting further medical examinations of the child as appropriate and necessary, and ensuring no child is discharged whilst concerns for their safety or well-being remain.

32. Children's Trusts must ensure that all assessments of need for children and their families include evidence from all the professionals involved in their lives, take account of case histories and significant events (including previous assessments) and above all must include direct contact with the child.
33. Local authorities must ensure that 'Children in Need', as defined by Section 17 of the Children Act 1989, have early access to effective specialist services and support to meet their needs
34. The Social Work Task Force should establish guidelines on guaranteed supervision time for social workers that may vary depending on experience.
35. The Department for Children, Schools and Families should revise Working Together to Safeguard Children to set out the elements of high quality supervision focused on case planning, constructive challenge and professional development.
36. The Department for Children, Schools and Families should undertake a feasibility study with a view to rolling out a single national Integrated Children's System better able to address the concerns identified in this report, or find alternative ways to assert stronger leadership over the local systems and their providers. This study should be completed within six months of this report.
37. Whether or not a national system is introduced, the Department for Children, Schools and Families should take steps to improve the utility of the Integrated Children's System, in consultation with social workers and their managers, to be effective in supporting them in their role and their contact with children and families, partners, services and courts, and to ensure appropriate transfer of essential information across organisational boundaries.

Interagency Working

38. The Department for Children, Schools and Families must strengthen Working Together to Safeguard Children, and Children's Trusts must take appropriate action to ensure:
 - all referrals to children's services from other professionals lead to an initial assessment, including direct involvement with the child or young person and their family, and the direct engagement with, and feedback to, the referring professional;
 - core group meetings, reviews and casework decisions include all the professionals involved with the child, particularly police, health, youth services and education colleagues. Records must be kept which must include the written views of those who cannot make such meetings; and
 - formal procedures are in place for managing a conflict of opinions between professionals from different services over the safety of a child.
39. All police, probation, adult mental health and adult drug and alcohol services should have well understood referral processes which prioritise the protection and well-being of children. These should include automatic referral where domestic violence or drug or alcohol abuse may put a child at risk of abuse or neglect.

40. The National Safeguarding Delivery Unit should urgently develop guidance on referral and assessment systems for children affected by domestic violence, adult mental health problems, and drugs and alcohol misuse using current best practice. This should be shared with local authorities, health and police with an expectation that the assessment of risk and level of support given to such children will improve quickly and significantly in every Children's Trust.
41. The Department for Children, Schools and Families should establish statutory representation on Local Safeguarding Children Boards from schools, adult mental health and adult drug and alcohol services.
42. Every Children's Trust should assure themselves that partners consistently apply the Information Sharing Guidance published by the Department for Children, Schools and Families and Department for Communities and Local Government to protect children.

Children's Workforce

24. The Social Work Task Force should:
 - develop the basis for a national children's social worker supply strategy that will address recruitment and retention difficulties, to be implemented by the Department for Children, Schools and Families. This should have a particular emphasis on child protection social workers;
 - work with the Children's Workforce Development Council and other partners to implement, on a national basis, clear progression routes for children's social workers;
 - develop national guidelines setting out maximum case-loads of children in need and child protection cases, supported by a weighting mechanism to reflect the complexity of cases, that will help plan the workloads of children's social workers; and
 - develop a strategy for remodelling children's social work which delivers shared ownership of cases, administrative support and multi-disciplinary support to be delivered nationally.
25. Children's Trusts should ensure a named, and preferably co-located, representative from the police service, community paediatric specialist and health visitor are active partners within each children's social work department.
26. The General Social Care Council, together with relevant government departments, should:
 - work with higher education institutions and employers to raise the quality and consistency of social work degrees and strengthen their curriculums to provide high quality practical skills in children's social work;
 - work with higher education institutions to reform the current degree programme towards a system which allows for specialism in children's social work, including statutory children's social work placements, after the first year; and
 - put in place a comprehensive inspection regime to raise the quality and consistency of social work degrees across higher education institutions.
27. The Department for Children, Schools and Families and the Department for Innovation, Universities and Skills should introduce a fully-funded, practice-focused children's social work postgraduate qualification for experienced children's social workers, with an expectation they will complete the programme as soon as is practicable.

28. The Department for Children, Schools and Families, working with the Children's Workforce Development Council, General Social Care Council and partners should introduce a conversion qualification and English language test for internationally qualified children's social workers that ensures understanding of legislation, guidance and practice in England. Consideration should be given to the appropriate length of a compulsory induction period in a practice setting prior to formal registration as a social worker in England.
29. Children's Trusts should ensure that all staff who work with children receive initial training and continuing professional development which enables them to understand normal child development and recognise potential signs of abuse or neglect.
30. All Children's Trusts should have sufficient multi-agency training in place to create a shared language and understanding of local referral procedures, assessment, information sharing and decision making across early years, schools, youth services, health, police and other services who work to protect children. A named child protection lead in each setting should receive this training.
31. The General Social Care Council should review the Code of Practice for Social Workers and the employers' code ensuring the needs of children are paramount in both and that the employers' code provides for clear lines of accountability, quality supervision and support, and time for reflective practice. The employers' code should then be made statutory for all employers of social workers.
32. The Department of Health should prioritise its commitment to promote the recruitment and professional development of health visitors (made in Healthy lives, brighter futures) by publishing a national strategy to support and challenge Strategic Health Authorities to have a sufficient capacity of well trained health visitors in each area with a clear understanding of their role.
33. The Department of Health should review the Healthy Child Programme for 0–5-year-olds to ensure that the role of health visitors in safeguarding and child protection is prioritised and has sufficient clarity, and ensure that similar clarity is provided in the Healthy Child Programme for 5–19-year-olds.
34. The Department of Health should promote the statutory duty of all GP providers to comply with child protection legislation and to ensure that all individual GPs have the necessary skills and training to carry out their duties. They should also take further steps to raise the profile and level of expertise for child protection within GP practices, for example by working with the Department for Children, Schools and Families to support joint training opportunities for GPs and children's social workers and through the new practice accreditation scheme being developed by the Royal College of General Practitioners.
35. The Department of Health should work with partners to develop a national training programme to improve the understanding and skills of the children's health workforce (including paediatricians, midwives, health visitors, GPs and school nurses) to further support them in dealing with safeguarding and child protection issues.
36. The Home Office should take national action to ensure that police child protection teams are well resourced and have specialist training to support them in their important responsibilities.

Improvement and Challenge

37. The Care Quality Commission, HMI Constabulary and HMI Probation should review the inspection frameworks of their frontline services to drive improvements in safeguarding and child protection in a similar way to the new Ofsted framework
38. Ofsted, the Care Quality Commission, HMI Constabulary and HMI Probation should take immediate action to ensure their staff have the appropriate skills, expertise and capacity to inspect the safeguarding and child protection elements of frontline services. Those Ofsted Inspectors responsible for inspecting child protection should have direct experience of child protection work.
39. The Department for Children, Schools and Families should revise Working Together to Safeguard Children so that it is explicit that the formal purpose of Serious Case Reviews is to learn lessons for improving individual agencies, as well as for improving multi-agency working.
40. The Department for Children, Schools and Families should revise the framework for Serious Case Reviews to ensure that the Serious Case Review panel chair has access to all of the relevant documents and staff they need to conduct a thorough and effective learning exercise.
41. The Department for Children, Schools and Families should revise Working Together to Safeguard Children to ensure Serious Case Reviews focus on the effective learning of lessons and implementation of recommendations and the timely introduction of changes to protect children.
42. Ofsted should focus its evaluation of Serious Case Reviews on the depth of the learning a review has provided and the quality of recommendations it has made to protect children.
43. The Department for Children, Schools and Families should revise Working Together to Safeguard Children to underline the importance of a high quality, publicly available executive summary which accurately represents the full report, contains the action plan in full, and includes the names of the Serious Case Review panel members.
44. Local Safeguarding Children Boards should ensure all Serious Case Review panel chairs and Serious Case Review overview authors are independent of the Local Safeguarding Children Board and all services involved in the case and that arrangements for the Serious Case Review offer sufficient scrutiny and challenge.
45. All Serious Case Review panel chairs and authors must complete a training programme provided by the Department for Children, Schools and Families that supports them in their role in undertaking Serious Case Reviews that have a real impact on learning and improvement.
46. Government Offices must ensure that there are enough trained Serious Case Review panel chairs and authors available within their region.
47. Ofsted should share full Serious Case Review reports with HMI Constabulary, the Care Quality Commission, and HMI Probation (as appropriate) to enable all four inspectorates to assess the implementation of action plans when conducting frontline inspections.

48. Ofsted should share Serious Case Review executive summaries with the Association of Chief Police Officers, Primary Care Trusts and Strategic Health Authorities to promote learning.
49. Ofsted should produce more regular reports, at six-monthly intervals, which summarise the lessons from Serious Case Reviews.

Organisation and Finance

50. The Department for Children, Schools and Families must provide further guidance to Local Safeguarding Children Boards on how to operate as effectively as possible following the publication of the Loughborough University research on Local Safeguarding Children Boards later this year.
51. The Children's Trust and the Local Safeguarding Children Board should not be chaired by the same person. The Local Safeguarding Children Board chair should be selected with the agreement of a group of multi-agency partners and should have access to training to support them in their role.
52. Local Safeguarding Children Boards should include membership from the senior decision makers from all safeguarding partners, who should attend regularly and be fully involved as equal partners in Local Safeguarding Children Board decision making.
53. Local Safeguarding Children Boards should report to the Children's Trust Board and publish an annual report on the effectiveness of safeguarding in the local area. Local Safeguarding Children Boards should provide robust challenge to the work of the Children's Trust and its partners in order to ensure that the right systems and quality of services and practice are in place so that children are properly safeguarded.
54. The Department for Children, Schools and Families, the Department of Health, and the Home Office, together with HM Treasury, must ensure children's services, police and health services have protected budgets for the staffing and training for child protection services.
55. The Department for Children, Schools and Families must sufficiently resource children's services to ensure that early intervention and preventative services have capacity to respond to all children and families identified as vulnerable or 'in need'.
56. A national annual report should be published reviewing safeguarding and child protection spend against assessed needs of children across the partners in each Children's Trust.

Legal

57. The Ministry of Justice should lead on the establishment of a systemwide target that lays responsibility on all participants in the care proceedings system to reduce damaging delays in the time it takes to progress care cases where these delays are not in the interests of the child.
58. The Ministry of Justice should appoint an independent person to undertake a review of the impact of court fees in the coming months. In the absence of incontrovertible evidence that the fees had not acted as a deterrent, they should then be abolished from 2010/11 onwards.



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