NSPCC

Evidence to

Lord Laming's Review of Child Protection

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Introduction

The National Society for the Prevention of Cruelty to Children (NSPCC) is the UK's leading charity specialising in child protection and the prevention of cruelty to children. The NSPCC aims to end cruelty to children by seeking to influence legislation, policy, practice, attitudes and behaviours for the benefit of children and young people. This is achieved through a combination of service provision, lobbying, campaigning and public education.

The NSPCC is represented on two-thirds of local safeguarding children boards (LSCBs) and provides child protection training and consultancy services to a range of public and private bodies. Recent users of the service include the Catholic Church, the NHS, the BBC, Ofsted and NACRO. The NSPCC also manages the Child Protection in Sport Unit with Sport England.

The NSPCC has more than 180 teams and projects in the UK and the Channel Islands. These services aim to:

- Prevent children being abused by working with parents and carers in vulnerable families to improve their knowledge and skills in safeguarding, and give children and young people someone to turn to through the provision of our Listening Services.

- Protect vulnerable children and young people from abuse by providing direct services in a number of settings, including schools and young people's centres. We also protect them by providing Listening Services. ChildLine became part of the NSPCC in 2006. It counselled 176,185 children in 2007/08 and has counselled more than two million children since 1986. The NSPCC Helpline, which adults can call when they are concerned about a child, made a total of 9,618 referrals to social services and the police in 2007/08.

- Ensure that abused children and young people are identified and effective action is taken to protect them and, by working with young people and adults who pose a risk to children and young people, to reduce the risk of abuse.

- Help children and young people who have been abused overcome the effects of abuse and achieve their potential.

Introductory points – safeguarding, child protection, and leadership

If one had been a visitor from another country to the UK during the last month it would be easy to conclude from the media coverage that the UK's child protection system and the way that the UK treats children is in crisis. At these times of high media interest in child abuse, the NSPCC sees it as part of its public responsibility and purpose to talk to the public through the media, and we have talked a lot in the last fortnight. The reaction to the death of Baby P feels different to us, in two respects, than in previous sad times; first, the depth of public outrage and in particular the view that after Victoria Climbié this should not have happened again; second, the reasons why this should happen again feel even more difficult to explain or justify.

The NSPCC has been keen to avoid adding fuel to the public outrage, and we continue to encourage support for professionals who so often do such a difficult job well.

We welcome the vision of Every Child Matters. There has been significant change in children's services over the last five years, with a strong drive for integration of the work of different agencies with responsibility for children's protection. With such a strong focus on structural change, however, some have asked whether sufficient focus has been maintained on children themselves.[i]

For local authorities, protecting vulnerable children should not just be a "priority" among other services, or one project among many. It should be a moral imperative every day, all of the time, for agencies that come into contact with children, and particularly those with statutory powers and duties. This continuous day-in day-out commitment requires leadership in every authority. It requires political leadership from central government. Effective child protection is so difficult that it does not just happen – it needs continuous and focused organisational leadership.

We believe it is possible that the current emphasis on the broad safeguarding agenda, with its emphasis on prevention and early intervention, could inadvertently have had the consequence of reducing the focus on protecting the most vulnerable children. We think it is also possible that the emphasis on supporting vulnerable parents might inadvertently have had the consequence of reducing the centrality on the vulnerable child.

It is parents and carers who kill children, not professionals. There is a limit to which professionals can take responsibility for deaths following maltreatment. There are few social workers, police officers, doctors and health visitors up and down the country to whom the killers of Baby P will not feel in some way familiar. What many of them deal with day-in and day-out is not appreciated by many members of the public, or politicians and officials. They face the dark side of people, deception and often aggression. It is in the nature of the caring professions to see the good in people. It is not surprising that "the rule of optimism" often prevails in practitioners and this has been identified as getting between practitioners and the truth in child abuse inquiry after inquiry.

Nor is it surprising that the positive and visionary – the concept of every child matters – is the desired outcome of government policy. But both personal and policy factors may have moved frontline staff away from being equipped to deal with the most damaged families and to protect the most vulnerable children. For practitioners to move from a facilitative to an investigative role needs a mandate and training. This area of work needs leadership – a moral mandate for practitioners –and it needs a distinctive set of workforce competences.

We think that there is also an issue of language. "Staying Safe" includes accident prevention, child abuse prevention, and child protection. "Safeguarding" includes promoting welfare, child abuse prevention and child protection. The breadth of definition is important because it recognises what needs to be done to achieve the best outcomes for children. But it may have had unintended consequences, moving policy and practice away from protecting the most vulnerable. *Child protection* involves distinct legal, policy and procedural requirements, and specific competences. We think that the words *child protection* need to be used when necessary – within the staying safe and safeguarding agendas – to reflect this. It is noteworthy that the administrations in Scotland and Northern Ireland decided not to use the term safeguarding – as a reflection of the need to acknowledge this distinctiveness, and maintain policy and professional focus on protecting the most vulnerable.

The emphasis we give to *child protection* in this submission might be construed as putting the clock back. It should not be. We do need to get better at prevention, but we still need a child protection service that is effective. One cannot, and should not, be at the expense of the other. There has never been a golden age of child protection. Central to our concerns are workforce issues that have been themes running through child abuse inquiries since Maria Colwell in 1974. For over 30 years the central issues have been:

- the relationship between the practitioner and the child and family;
- the relationship between the practitioner and their first line manager/supervisor.

In more recent times, local and national leadership has become a recurrent theme in these inquiries. We refer to local and national *leadership* here in a slightly different way from the discourse about accountability. All of our experience with organisations tells us that effectively protecting the most vulnerable children is so challenging that it will not happen by accident. Committed leadership is required to drive this work locally and nationally.

We believe that high-level political leadership is needed. It is notable that some areas of child protection, such as Internet safety and sex offender management, regularly have a high political priority and often prompt immediate high-level government action. However, the routine day-to-day child protection work rarely makes headlines unless a child dies. It is time that changed.

The NSPCC is extremely concerned about the fragility of the system. Our LSCB representatives and colleagues in partner agencies tell us that their organisations are struggling to cope with the number of new initiatives to implement, and a workforce that has a number of vacancies, is relatively inexperienced and is being overwhelmed by the complexity of what is being asked, while being taken to task by the media, either for failing to intervene or for intervening.

We do not believe that just putting more money into the system is a universal panacea. But we are concerned about the balance between the level of resources invested in organisational systems and those invested in building the capacity and skills of people.

Central government leadership must not only set clear frameworks for child protection, but also review the funding available to local authorities and trusts to enable them to properly invest in a workforce that is competent, well managed, well led and sufficient in size.

There is a need to restore public confidence in the system that has, and continues to have, effectively protected many children each year. It is important that a review of the system should ensure a central focus on children and their needs and best interests. Children need to be safe (physically) and to feel safe (emotionally).

We have organised our submission as answers to your three questions, although there is considerable overlap. To avoid repetition we have referred to previous paragraphs when necessary.

Q1. What good practice has been successfully achieved in safeguarding children since the publication of the Victoria Climbié Inquiry report? We would like you to set out the key features of this good practice, and whether it is being universally applied across the country, particularly in relation to:

- the effective implementation of safeguarding systems and procedures;
- inter-agency working;
- the development and deployment of professional workforce capacity; and
- effective systems of accountability.

We have, in Appendix A, set out some of the achievements of the NSPCC Training and Consultancy service. In Appendix B we set out examples of some of the work of our children and young people's services.

1.1 The Every Child Matters programme has the potential to be the most significant achievement for children in recent times. The PSA 13 for the Staying Safe outcome is a real achievement too in driving forward delivery.

1.2 There have been many examples of good practice since the publication of the Victoria Climbié Inquiry report and it is important that models of good practice should be widely promoted and shared. We are aware that there is much information on good practice available from the Department for Children, Schools and Families (DCSF) and other government departments, which have been very active in promoting such practice to professionals to support new guidance and policy frameworks. Examples include the National Service Framework for Children, Young People and Maternity Services database of good practice, the DCSF guidance on Joint Commissioning and the recently published "Exemplars of LSCB Effective Practice" (DCSF, July 2008). The exemplars include information about good practice in relation to issues such as funding, the engagement of partners in LSCB work and linking with children's trusts, as well as examples of effective initiatives to tackle issues such as co-sleeping and commercial sexual exploitation.

1.3 Some NSPCC projects have been included in certain databases, and we have set out, in the Appendices, some examples of the work that we have been doing since the publication of the Inquiry Report, as some of these initiatives may be of interest to the Review.

1.4 Our concern about much of the good work that has been happening in recent years, however, is that it is frequently time-limited or conducted only on a pilot basis. One example of time-limited funding was the Children's Fund. While some such projects may be sustained as part of mainstream provision once dedicated funding streams finish, this is often not the case.

1.5 In relation to pilots, we have been particularly encouraged by the Family Nurse Partnership (FNP) pilots, which have shown promising results and are a good demonstration of the benefits of early support work with vulnerable first-time young parents, in this case from early pregnancy and for the first two years of the child's life. In this joint DCSF/DH pilot, FNP nurses build a close, supportive relationship with the whole family and guide mothers to adopt healthier lifestyles, improve their parenting skills, and become self-sufficient. We are pleased that in March 2008 the number of pilot areas was increased to 30, and hope that if the overall evaluation of the programme is positive that this model of working will become universally available in order to provide more sustained support to parents who need it.

Q2. What are the key barriers, including in the legal process, that may impede efficient and effective work with children and families that may be preventing good safeguarding practice from becoming standard practice everywhere, for example in deciding whether an application should be made to take a child into care? Is the right balance being struck between the correct application of processes and the needs of the child?

2.1 Workforce: competence; capacity; inter-agency working; systems of accountability

2.1.1 At the core of an effective safeguarding system there should be a workforce that is fully staffed, well trained and well supported. Good quality relationships between the child, their parents and the professionals working with them are vital in most cases for a child to be protected and to do well.

2.1.2 It is clear from what we have learnt about aspects of professional practice from the Joint Chief Inspectors' report, Ofsted's recent review of serious case reviews and the latest inspection of Haringey, that further action is urgently needed to ensure the workforce is both competent and confident to make the right judgements and to take the necessary actions to protect children and to restore public confidence in professionals.

2.1.3 The report of the inquiry into the death of Victoria Climbié contained 18 recommendations related to training. Since then, considerable attention has been paid to the need to raise standards of professional practice with children and families and to create a world-class children's workforce. There have been many positive developments, some of which are still in their early stages, including: new training resources, the common core of knowledge and skills, the NQSW Project and investment in leadership and management training. It is arguably too early for these to have had a significant impact on practice.

2.1.4 Many of the new developments have taken a holistic/generic approach to raising standards, covering most or all five of the Every Child Matters outcomes. This breadth of approach is good and provides necessary building blocks, for example in relation to child development.

2.1.5 Few of these developments, however, have focused specifically or exclusively on safeguarding children or on improving the skills to work with children and their families when children are at risk of significant harm. Insufficient attention has been given to two things: a) the depth and detail of knowledge required for child protection work, and b) the practical skills development needed fully to equip practitioners and managers to make sound professional judgements, especially when it comes to safeguarding.

2.1.6 While *Building Brighter Futures*: *Next Steps for the Children's Workforce* makes a useful distinction between the core and wider workforce, it has only two paragraphs on safeguarding (3.25 and 3.26); these focus on extending knowledge about safeguarding across the workforce and on safer recruitment. There is nothing on deepening and strengthening the skills of the core children's workforce in relation to children in need of protection.

2.1.7 Further, many developments are projects or pilots, which therefore affect only particular geographical areas or pockets of practice. Funding is time-limited and relies on local authorities and other employers to adopt and fund good practice in the future. There is insufficient investment in comprehensive and sustainable improvement.

2.1.8 Much implementation of guidance or new programmes of training and development is left to the discretion of LSCBs and Directors of Children's Services, to resource as they see fit. The most recent Joint Chief Inspectors' report highlighted uneven access to training. Training resources allocated by LSCBs vary significantly; in many areas inter-agency training is seriously under-resourced and cannot equip professionals to fulfil the requirements of *Working Together to Safeguard Children.*

2.1.9 Working with manipulative, violent, and possibly sadistic, adults is emotionally draining, not to mention frightening. To defend oneself it is common to put up protective emotional barriers, which prevent accurate assessments. There is too little emphasis in training for social workers and for primary health care staff, such as midwives, health visitors and general practitioners, on child development, on child protection and on the new techniques that are available to detect problematic relationships at an early stage.

2.1.10 These are difficult issues and are much worse when providing an emergency response. It is important to know whether progress has been made in ensuring that expert advice can be sought out of hours.

2.1.11 Child care cases have arguably become more complex over the last 20 years as a result of societal and cultural changes, such as diverse family structures and alcohol and substance misuse. It is therefore important that professionals in these circumstances have opportunities to reflect. Supervision becomes vital and yet we know from Ofsted's recent review of Serious Case Reviews that: "*There were general criticisms about the absence of management overview, especially in cases of chronic neglect where the role of managers should be to 'stand back' and see the bigger picture. Instead they tended to be reactive and make decisions on the basis of specific incidents as they arose*."

2.1.12 A number of authorities used to have a policy that social workers could engage in child protection work only after they had a certain amount of post-qualifying experience, along with satisfactory completion of training. We know from our Training and Consultancy service that this is no longer the norm, partly because staff shortages make it very difficult to manage. Further, there is no set requirement for the amount of post-qualifying training that social workers should have.

2.1.13 Through our research, inspections, practice and work with external agencies as a training provider, we have identified a number of skills gaps:

- Working with cases of child neglect (see para 2.18);
- Working with the families of children with a child protection plan to achieve change;
- Analysis, professional judgement and decision-making in situations where there are child protection concerns or children are known to be at risk of significant harm;
- Working with passively or actively hostile, or resistant, individuals
- Knowledge and understanding of child development, including observational skills;
- Engaging and communicating effectively with children and young people.

2.1.14 Professionals' responses are affected by the leadership and support they receive. Staff work in isolation and are personally demonised for system failures, which in turn causes professional fear that can paralyse effective care services (Reder 1993)[ii]. The campaign by one of the tabloids to identify and vilify the staff involved with Baby P only serves to reinforce this and can only be unhelpful in the long term.

2.1.15 There is much anecdotal evidence to suggest there is an over-emphasis on managerialism, targets, form-filling and procedures being an end in themselves, all of which have a negative impact on professional practice. Our projects have told us that:

> *"The primary focus of local authorities is on meeting targets …"* and *"… the target-driven culture is destroying sound professional judgement among managers in children's social services ... We have all experienced children's services that are rated as two or three star services when we know that the standard of much professional practice is lamentable. But they meet their targets."*

2.1.16 These comments suggest that the findings of the latest Ofsted inspection of Haringey (Dec 2008)[iii] would be likely to be replicated in similar assessments of some, though not necessarily all, other children's services departments.

2.1.17 Staff turnover and vacancy rates in social work are a continuing problem in many parts of the country: the average vacancy rate for field social work is 9.8 per cent, but is much higher in areas like London and the South East.[iv] This means that high levels of agency staff are being used in the children's social care workforce, particularly in large cities like London.

2.1.18 Our LSCB representatives have identified the quality of supervision of frontline workers as essential to effective child protection. However, this is often deficient and inadequate, as the following comments highlight:

- *"Quality of supervision, analysis and professional judgement is variable across agencies but [of a] markedly poor standard at frontline social worker level."*

- *"…above all, reflective professional supervision on a regular basis, and consultation with other skilled, knowledgeable professionals* [is required to safeguard children]*. Very few local authority social workers, in my experience, have access to these."*

2.1.19 Our representatives have expressed concern about workloads for children's social care staff. The demands on social workers to complete paperwork and the Integrated Children's System (ICS) have been described as excessive, and they are acting to limit workers' contact with children:

- *"Practitioners complain that it* [ICS] *is extremely time consuming… and that it often makes complex situations appear atomised and over-simplified."*

- *"Social workers may have ostensibly low caseloads of say eight cases, but this can involve numerous children, for example one local social worker has 43 children in [their] caseload."*

- *"The increasing amount of time spent completing forms, often to a level which doesn't include careful analysis of the issues facing a child, hasn't offered a great deal to the understanding of a child's needs but has taken away significant amounts of time that might have been spent on direct work with children."*

- *"The turnover of staff is constant. New social workers struggle to cope…"*

2.1.20 There is an understandable and growing reluctance to undertake child protection work in both health and social work, creating serious difficulties in appropriately allocating work to suitably experienced practitioners. As a number of media commentators have said, this is only going to worsen as a result of the current furore.

2.1.21 The issues of staffing are the same across the children's workforce. A recent survey of community practitioners and health visitors found that 25 per cent thought "another Victoria Climbié could happen in their NHS trust" and identified a need for more investment in health visiting.[v] Health visitors are an important part of the workforce, especially for babies and young children under the age of three. However, they face similar pressures and have the same concerns as the social care workforce. A recent survey by the CPHVA of health visitors found that:

- 18.1 per cent have responsibility for more than 1000 children;
- 38.9 per cent have responsibility for more than 300 families (the CPHVA recommends 300 families as the maximum number for delivering effective interventions);
- 63.6 per cent did not think it was possible to offer a core service;
- 69.2 per cent did not think they had adequate resources, both in terms of health visitor capacity and other support services, to respond to the needs of the most vulnerable children.[vi]

2.1.22 There is also a growing crisis in paediatrics, with the president of the Royal College of Paediatrics and Child Health, Dr Hamilton, saying: "*We do not currently have enough numbers of paediatricians to provide comprehensive safe services for children, and the government must recognise that we need to be resourced to do so*" (May 2008).

2.1.23 Staffing and training resources are clearly inadequate to meet the need at universal level. The development of the role and capacity of health visitors was recommended by Sir Donald Acheson in his review on reducing health inequalities 10 years ago[vii], but this is still to be fully acted on. We are clear about the need to have a robust universal health visiting service. This must comprise highly trained, skilled professionals, confident in identifying potentially vulnerable children and knowledgeable about how difficulties and protective factors interact so that they can respond effectively to both prevent and identify significant harm.

2.2 ContactPoint

The NSPCC welcomes any system that promotes faster and better information-sharing among professionals working with children, including ContactPoint. However, the key to safeguarding children is how effectively professionals use that information.

2.3 Leadership and accountability

We are concerned about whether senior management in services understand enough about safeguarding including the child protection system and the support needed from them for it to be effective, in part because as an issue child protection is not given high political priority (see above). Furthermore, two-thirds of Directors of Children's Services have an education rather than a social work background, and we are also aware that the engagement of health agencies in children's trusts has been particularly challenging. In 2004, the Scottish Government asked for a joint letter of assurance from the chief executives of the local authority, police and health boards that they were satisfied that they had the right things in place to protect children. This was challenging, but middle managers and those dealing with child protection reported that it meant for the first time that the senior management team started to understand what was required of them.

2.4 Assessment

2.4.1 Good assessment requires competent practitioners. We have expressed concerns about workforce skills above. Our LSCB representatives have reported major concerns about inadequacy of assessments undertaken by social workers into the needs of children, including risk assessments:

> *"Unless there is effective, timely and accurate assessment at the point of contact, unless relevant information is sought and analysed, all else becomes so much background noise."*
>
> *"Have social workers and managers got the requisite skills?"*
>
> *"In Northern Ireland our children's framework has included risk, unlike Every Child Matters and I think that is helpful."*
>
> *"Many newly qualified social workers are unable to analyse or understand complex issues…"*
>
> *"Core assessments may be improved as completed on time but some are really poor quality and barely constitute an initial assessment."*
>
> *"Improved training of managers* [is required] *in working with dangerous families and in how they can develop complex assessment skills in their services to better understand families that harm children."*
>
> *"Risk does not seem to be broadly understood."*
>
> *"Assessments which reach us can be superficial in the extreme... there* [can] *be a huge deficit in understanding."*
>
> *"There's a lack of systemic approach to risk analysis and risk management from all agencies."*

2.4.2 We have been, and remain, concerned about the lack of acknowledgement about risks to a child in the assessment framework that is currently used by social workers in England and Wales. Significantly, the assessment frameworks that have been or are developing in Northern Ireland and Scotland are explicitly addressing this issue.

2.4.3 Being able to diagnose effectively in the area of child protection is fraught with difficulties. Poor assessments can do more harm than good. At present health visiting and social work practitioners are not being offered training that can give them confidence in assessing vulnerable children. For example, understanding of the attachment process is now relatively sophisticated and there are measures such as CARE-Index[viii] and the Working Model of the Child Interview[ix] available to pick up potential problems in relationships. These types of assessment tool will indicate when parents need more support and on occasion when parents are not able to make the changes that are necessary to form an adaptive and protective attachment with their child. There are also a variety of interventions that can be used to help the developing relationship get back on track.

2.4.4 The Common Assessment Framework (CAF) was introduced in 2006 with every local authority expected to have implemented it by now. Our own anecdotal evidence does suggest a variation in practice. We note the comment from Ofsted that: "*The current practice of working within the Common Assessment Framework and its focus on 'children in need' makes it even more critical that all staff are aware of child protection issues and how to identify early indications of harm or abuse"*. [p25]

2.5 Thresholds

2.5.1 For many years organisations have grappled with the issue of thresholds for intervention and allocation of services, both for children in need and for children in need of protection. Anecdotal evidence does suggest that children may not receive a service until the situation becomes extremely dangerous for the child and the potential for successful engagement with the parents/abuser are reduced.

2.5.2 Specifically, our LSCB representatives have reported high thresholds for intervention, which are putting more children and young people at risk – some reporting that this impacts on the adolescent age group significantly. For example:

> *"Thresholds are absurdly high."*
>
> *"Too many social workers and managers think the legal dept decide thresholds."*
>
> *"Thresholds…the same as criminal justice thresholds operated by the Police."*

2.5.3 The Joint Chief Inspectors' reports in 2005 and 2008 both highlighted these issues: "*In some areas thresholds for referring children to social care services remain high and a good understanding of thresholds across all agencies, while improving, is not yet fully established."*

2.5.4 At present, we have a system operating on a deficit model, in which needs must be high and immediate before coordinated multi-agency responses can kick in. At the same time, practitioners in all services across the UK have a common complaint that others fail to listen and respond when they notify them of concerns about a child. There are a number of reasons for this, including failure to understand roles, defensive practice and a lack of trust, all of which contribute to children and families being moved from pillar to post before they receive a service.

2.5.5 Based on our engagement with services, we believe that thresholds are regularly determined by the availability of resources and cost considerations, rather than by the needs of children.

2.5.6 This can be exacerbated where independent reviewing officers are managed by senior managers in children's services.

2.5.7 Individual LSCBs have produced guidelines for local thresholds, but there is no nationally agreed threshold, although the standards established by the National Service Framework for Children, Young People and Maternity Services are sound and constitute excellent guidance for the services that should be available to children, young people and their families. Formalised local thresholds are only useful when resources (financial and human) exist to support them.

2.6 Listening to the child

We note with concern the finding from Ofsted that in the majority of the serious case reviews there is a "*failure of all professionals to see the situation from the child's perspective and experience; to see and speak to the children; to listen to what they said, to observe how they were and to take serious account of their views in supporting their needs*"[x].

Paragraph 5.4 of *Working Together to Safeguard Children* talks about the need for professionals to be child-centred, but does not emphasise seeing the child alone.

2.7 Resources

2.7.1 Thresholds are linked to resources, which are a contentious issue. It is evident that there is not a direct relationship on the local authority spend per child, and the beneficial outcome for children. But of course the amount, and the use of resources do matter. According to the Institute of Fiscal Studies[xi], the DCSF allocated six per cent of its budget (£60.9m) to children's services in 2007/08. Clearly there has been significant investment in areas such as Sure Start and ContactPoint. A significant majority of this investment has been in new initiatives and processes such as ContactPoint, the CAF and the Integrated Children's Service system. We believe that it is time to invest in people and workforce development.

2.7.2 As an Action for Children report notes "*In England alone, there have been 46 initiatives launched since 1987 – on average they last only 3.9 years, and over 60 per cent of these initiatives have begun in the past four years."*[xii] In this context it is easy to argue both that resources have been invested, but also that resources continue to be an issue. As inspectors noted "t*he level of resources available to LSCBs is very variable...the development of preventative services is inhibited by the wide range of funding streams and funding being time-limited*." [xiii]

2.7.3 The quality of safeguarding training is at risk from under-resourcing and cost-cutting measures. We are aware from our extensive training networks and the training requests we receive that employers facing resource pressures are trying to cut the costs of training, for example by reducing the length of courses, and increasing the numbers attending each course.

2.8 Inspection

2.8.1 Others are better able to comment on the structures and processes of inspection. The recent JAR inspection of Haringey flagged up some of the weaknesses in the current inspection regime, especially with the grading being based on performance data. Through our LSCB representatives and other contacts, we are aware of a general dissatisfaction, with a view that Ofsted focuses too much on procedures and structures.

2.8.2 Ofsted has recently ended their consultation on the planned processes for inspecting safeguarding and LAC arrangements. We have set out some of our concerns in our response to that consultation and want to emphasise here our concern that there is an over-emphasis on self-evaluation. Inspections need to ask the right questions, inspectors need be informed and understand the systems they are inspecting; they need to be able to spend time observing and to be able to talk to others in the safeguarding system to clarify how well the organisations work together and how effectively the system works as a whole. Analysing performance data does not get into the corners of what is really happening between practitioners and clients – and the quality of what is happening.

2.8.3 In order to inspect, one needs to understand what happens at the coal face and what good practice needs to look like. One then needs reliable tools that can help you to assess the quality of the practice. It is also important that the inspection process is transparent with the marking regime clear and understandable, not just to inspectors but to practitioners and service users.

2.8.4 We assume that Ofsted has analysed the disparities between the inspections in 2006 and 2007 and the most recent inspection. It would be helpful for that analysis to be published in order to help services and the public understand the disparities and how they had come about. It is also important that it should inform the final process that is decided on for inspection of children's services.

Legislative

2.9. 9 The Public Law Outline

2.9.1 The Public Law Outline was introduced in April 2008 and at the same time there was major increase in fees that local authorities have to pay to commence court proceedings. We believe that together they have led to a dramatic decrease in the number of applications for care proceedings. This coincided with an increase in the use of kinship care and other voluntary arrangements. There are reports of an increase in numbers of proceedings taken since the Baby P case was publicised (The Independent, 23rd Nov 2008). This indicates that decisions about care proceedings are very definitely being influenced by external factors, whether it is the PLO, the increase in fees or cautious practice resulting from high-profile cases such as that of Baby P.

2.9.2 An investigation into these issues needs to form part of the review. There is a need to examine cases to determine if the swings in numbers of applications are justified on the basis of providing protection for children where needed or if they are due to unjustified reactions to external events. If the latter, then steps need to be taken to address these problems.

2.10 Section 20 of the Children Act 1989

2.10.1 The use of Section 20 is causing us concern. Section 20 presupposes that there is a safe adult able to share parental responsibility and there is no doubt that Section 20 is critical to maintain partnership work with families and to avoid unnecessary formal processes. The legislation and guidance is clear as to the circumstances in which Section 20 of the Children Act 1989 should be used, but we are aware that on occasions Section 20 may be used inappropriately or not in the best interest of the child.

2.10.2 Section 20 has been used inappropriately, in our experience, with unaccompanied minors where contact with their birth family is severed through the transit process/or the lack of contact with the birth family was a pre-disposing factor for the minor leaving their home country. Also, while it is used to see if rehabilitation is a realistic option, the decision is not automatically revisited once a decision has been made that a child cannot return. In these circumstances, it is important that the decision regarding Section 20 be revisited and the option of the local authority becoming the full parent be seriously considered, as we know that children/young people in long term care have decreasing contact with their birth family.

2.11 Familial homicide

2.11.1 In 2003, the NSPCC published *Which of you did it? Problems of achieving criminal convictions when a child dies or is seriously injured by parents and carers*. The report discussed the problems of achieving criminal convictions when a child dies or is seriously injured by parents or carers. A key recommendation was that new legislation should be drafted to require those who had responsibility for the care of a child who suffered injury (including injuries resulting in death) to account for the period when the injury was sustained. This led to the new offence of familial homicide: causing or allowing the death of a child or vulnerable adult in the Domestic Violence Crime and Victims Act 2004. The Home Office amended the proposed legislation to include the death of vulnerable adults as well as children but to exclude serious injury from the offence. The exclusion of serious injury from the legislation was a great disappointment to the NSPCC.

2.11.2 It should be noted that without the current Familial Homicide legislation, the Baby P case would probably not even have been prosecuted because there would not have been sufficient evidence to do so. It might have been possible to prosecute for neglect, but there are cases when there is not enough evidence for neglect where a baby has died. The NSPCC's position (and that of the Which of You Did It? working group) has always been that the legislation should cover not only the death, but also the serious injury, of a child.

2.12 Equal protection

2.12.1 Social workers and other professional need an unequivocal mandate to tackle violence to children. Smacking children is violence. To tackle all forms of violence that some children experience, the law should be unequivocal in the protection it affords and give children equal protection under the law on assault by removing the parental defence of "reasonable punishment", available under s58 of the Children Act 2004. This must be accompanied by widespread public education about positive parenting. Both these measures are needed; neither, alone, is sufficient to achieve cultural and behavioural change.

2.12.2 In a survey for the Children are Unbeatable! Alliance, 82 per cent of parenting practitioners working in Sure Start projects and children's centres said that s58 hinders their work with children and families, and 20 per cent said that it hinders this work "a lot". Only one per cent said that it helps them.[xiv] Seventy-seven per cent of the sample said that "banning smacking" would help them achieve their professional aims.

2.13 Local Safeguarding Children Boards (LSCBs)

2.13.1 We have consulted with our representatives on LSCBs about the key issues in the work of LSCBs as they experience them; the following is a summary of the key issues they have raised:

2.13.2 NSPCC representatives perceive that the most influential members of LSCBs are health professionals. This is not simply about a numerical influence in terms of numbers, but also a reflection of the willingness and ability of health professionals to speak out and influence the agenda of the Board. Children's services and the police follow close behind health in terms of influence. NSPCC representatives report that, in their experience, the least influential members of LSCBs, in terms of ability to make their voices heard and affect the LSCB agenda, are probation, CAFCASS and education representatives. Further work would need to be done to measure whether those who appear most influential during LSCB meetings are equally influential within their own organisations. Similarly, those with a lower profile on the LSCB may nonetheless be effecting significant change within their organisation to improve child safeguarding.

2.13.3 Ofsted has previously commented on the value of independent Chairs for LSCBs. We support the view that LSCB Chairs should be independent. Our LSCB representatives have expressed concerns that Directors of Children's Services who chair LSCBs lack independence and that some of them shape agendas to suit their own agency requirements. Our representatives expressed greater negativity about the effectiveness of LSCBs in cases where the Chair is the DCS, and this includes a wider concern about the quality of chairing. They note that independent Chairs often facilitate challenge and encourage greater transparency between agencies, including children's social care, about local safeguarding practices.

2.13.4 LSCBs were generally deemed by NSPCC representatives to be willing to listen to identified child protection concerns, although this does not always translate into action. The three most pressing issues facing LSCBs are:

- Serious Case Reviews (SCRs): the volume of SCRs, ability to recruit independent authors, learning lessons from the process, monitoring and implementing action plans;

- Child Death Overview Panels (CDOPs): establishing the CDOP, training, managing additional workload, aligning the CDOP and SCR processes;

- Auditing/reviewing/monitoring LSCB activity: implementation of audit processes, performance frameworks, measuring outcomes.

2.13.5 In advocating independent chairing of LSCBs, the NSPCC is committed to the principle that the LSCB should not be subordinate to, or subsumed within, the Children's Trust arrangements in a way that might compromise its separate identity and independent voice. However, the independence of an LSCB Chair does not in itself guarantee effective leadership.

2.13.6 Resourcing of LSCBs is also a key issue that needs attention. There is no set requirement for the level of contribution made by different agencies to the LSCB, which results in great variation in the resources available to them to fulfil their remit. For example, our LSCB representatives have commented that LSCBs are often compromised in their ability to appoint an independent Chair, and other essential posts to support the work of the Board, by their limited financial resources.

2.14 Serious Case Reviews (SCRs)

2.14.1 Serious case reviews are an essential element of both local and national action to improve safeguarding practice across the country.

2.14.2 Much has been said recently about SCRs, with a number of calls for the full Serious Case Review (SCR) on baby P to be published. We endorse the view that is set out in your letter of the 1st December 2008 to the Secretary of State for Children, Schools and Families. Clearly, the purpose of undertaking an SCR is to identify if any lessons can be learnt about the ways in which organisations work together to safeguard and promote the welfare of children (para. 8.2 *Working Together to Safeguard Children*). They are not, as the guidance states, "inquiries into how a child died or who is culpable".

2.14.3 Publishing full SCR reports would change the climate in which they are produced, reduce their value and potentially compromise the effectiveness of the SCR process. The publication of the entire review documents would inevitably affect the willingness of agencies to be open and candid about their involvement with a family where they may have failed in their practice. Organisations would be defensive and the likelihood is that they would not provide full disclosure or

cooperation. Thus, the process would move from focusing on what could be learnt to focusing on legalistic technicalities, resulting in an end-product that is bland and has no value for anybody.

2.14.4 Equally important is the right of confidentiality owed to children and non-abusing carers within the family. The ability to move on from the abuse will be made that much harder if their names are publicly revealed.

2.15 Child Deaths Overview Panels

The introduction of Child Death Overview Panels (CDOPs) in April 2008 provided LSCBs with an extended duty to review information on all child deaths. While the findings from a review of early pilots indicate that it is a process widely regarded as being worthwhile and embraced with considerable enthusiasm, the effectiveness of these panels is yet to be tested. In terms of the identification of child maltreatment deaths, if panels are working well the number is very likely to increase. In the US, for example, panels have uncovered a significant proportion of child abuse deaths that were initially misdiagnosed or misclassified. The method and timing of evaluation of panels is as yet unclear, but it will be crucial in determining the extent to which they are contributing to the better identification of deaths through abuse and neglect.

2.16 Specific groups

There are specific groups of children who are more vulnerable to abuse.[xv] We particularly wish to highlight the needs of three groups who are of significant concern: children under the age of five, disabled and deaf children, and children who are neglected.

2.17 Children under five

2.17.1 The incidence of abuse to young children under the age of five, and especially babies, is a cause for major concern. The death of Baby P clearly highlights the increased vulnerability of babies. Infants under the age of three years are the most vulnerable to abuse and neglect. Forty nine per cent of children featured in the study on child deaths and serious case reviews were under the age of one with another 20 per cent under the age of five.[xvi] Recognition must be given to the fact that infants under the age of three are:

- More likely to be cared for solely within home environments;
- Least likely to be seen on a regular basis by child care professionals, such as teachers or nursery nurses; and
- Experiencing rapid brain development, which may be adversely affected by hostile interactions[xvii] and high levels of stress hormones.[xviii]

2.17.2 A primary preventative public health approach should be taken where parents and infants are supported from the outset. This is outlined from pregnancy and for the five years of life in the comprehensive Child Health Promotion Programme (CHPP)[xix]. The CHPP relies on a highly skilled universal workforce to identify children who need more support to enable the next stage of "progressive universalism", in which children in need receive extra services. The CHPP cannot be implemented unless staff are trained, properly supported in teams with expert supervision and have manageable caseloads.

2.18 Neglected children

2.18.1 In research undertaken by Gardner[xx] we found that the scale and nature of the problem requires a systemic and systematic response. Half of all children who have a child protection plan have a plan because they have suffered neglect; this rises to three-quarters of children in some areas when joint categories of registration are included. Neglect is identified as a form of significant harm.

2.18.2 The response to neglect needs to be active and pre-emptive**.** Child neglect is always a sign of serious underlying problems that must be addressed if children are to be safeguarded. A systemic response requires practitioners to be equipped to deal preventively with early signs of child neglect as well as to be ready to step in if a child's health and welfare are endangered. It also needs to be multi-layered – extending reaching from families to government – and multi-agency – from all those working directly with children, to all agencies whose work affects outcomes for those children.

2.18.3 In *Working Together to Safeguard Children* neglect is defined as:

> *"The persistent failure to meet a child's basic physical and/or psychological needs likely to result in serious impairment of the child's health and development".*

However, the use of the term "persistent" in *Working Together* suggests that neglect has to be long-term before a care order can be made. This can result in the courts being unwilling to accept neglect as significant harm without major traumatic incidents or evidence of developmental damage over a prolonged period. Thus, action is likely to be too late, with harm having already occurred, even when this was foreseeable due to poor parenting practice. The difficulty is compounded by the wording of *What to do if you're worried about a child* (DfES 2006), which states that "there are no absolute criteria on which to rely when judging what constitutes significant harm. Some children live in families where their health and development are neglected. For them, it is the corrosiveness of long-term emotional, physical or sexual abuse that causes impairment to the extent of constituting significant harm".

2.18.4 This could be interpreted as suggesting that neglect meets the significant harm threshold only when it is prolonged; and that children who are neglected have to undergo "corrosive" abuse before formal intervention can take place. Short

of a potentially criminal incident, neglect does not constitute significant harm unless and until it endures over time. Gardner found that "Even when children showed strong evidence of neglect, a parent's action or inaction did not necessarily meet the criminal threshold, while recurring incidents just below the 'significant harm' threshold were often not recorded and considered for their cumulative effect as meriting intervention under the Children Act".

2.18.5 Gardner found in a series of interviews with practitioners that many thought that these descriptions create problems in convincing the courts that neglect in the form of inconsistent patterns of care can constitute significant harm. Practitioners also reported spending a lot of time and energy on the question "What degree of failure of care does this child need to undergo, for how long, before there is a mandate for intervention?" For some, this meant permanent anxiety because monitoring could not be continuous, inconsistent care was hard to track and recurring failures could escalate to endanger a child's health and welfare.

2.18.6 There are important questions about what constitutes "persistent failure" to meet a child's needs or "significant impairment" to their health or development. The term "persistent failure" means that workers are often asked to build up evidence of poor care and damage to a child's development over time, for example from missed health appointments. Having waited, they are then challenged as to when and why poor care became a matter of significant harm. They may have to decide whether to allow deterioration in the standard of parental care or put in what may have to be semi-permanent support systems that effectively substitute for the parent.

2.18.8 There are also problems in specifying what is reasonable to expect from any particular parent, especially in circumstances of stress, duress or disability.

Thus, the current legal and policy framework encourages:

- a view of neglect as only a chronic phenomenon and hence waiting for neglect to persist before intervening;
- practitioners to see harm caused unintentionally as less serious and more remediable, when this may not be the case;
- unwillingness on the part of the courts to accept neglect as significant harm without traumatic incidents or evidence of developmental damage over a prolonged period; and
- a minimising of how even short-term neglect can seriously compromise outcomes for children.

2.19 Deaf and disabled children

2.19.1 Research shows that deaf and disabled children are at increased risk of abuse. One large-scale study from the United States[xxi] found that disabled children are 3.4 times more likely to be abused compared to non-disabled children. This increased risk of abuse is recognised by the Government in, for example, *Working Together to Safeguard Children*.

2.19.2 Barriers to the protection of disabled children exist at all stages of the process. The National Working Group on Child Protection and Disability (NWGCPD) report "*It doesn't happen to disabled children": Child protection and disability* set out the key issues relating to risk and safeguarding of disabled children.

2.19.3 The NSPCC welcomes the progress that has been made on some of the Report's recommendations, such as the recent focus on disabled children within the Staying Safe Action Plan. However, our concern is that improvements in policies are often failing to lead to changes in practice.

2.19.4 Many of the issues and concerns outlined within the NWGCPD's report remain. Deaf and disabled children are at increased risk of abuse for a number of reasons, including:

- Attitudes and assumptions, for example a lack of awareness of risk, reluctance to believe that disabled children are abused, and possible indicators of abuse being mistakenly attributed to a child's impairment;
- Service provision, in particular the skills gap that exists between child protection workers and those working with disabled children, the lack of child focus, the lack of effective planning and co-ordination of services and the failure to provide effective PSHE and safety skills work and failure to provide a vocabulary that will empower a child and enable them to communicate abuse; and
- The child's impairment, for example the intimate care they may receive from a number of carers, their lack of awareness or ability to communicate abuse.

2.19.5 "Deaf children are not just hearing children who can't hear". Deaf children do not all fit into one easy category and there are huge disparities regarding needs. The picture is more complex than language alone. Evidence from a recent NDCS report[xxii] suggests that services are ad hoc. There are isolated areas of good practice, but generally the message is that there has been no improvement to the system. It is not actually working for deaf children.

2.19.6 Black and minority ethnic (BME) deaf and BME disabled children face further risks and barriers due to attitudes and assumptions relating to language and communication issues and lack of culturally sensitive services.

2.20 Confidentiality – "confidential space" for children

2.20.1 The NSPCC acknowledges that keeping children safe from harm requires professionals and others to share information. It also recognises the need to balance that principle with the need for children and young people to share confidences while retaining a measure of control over how sensitive information is processed and shared.

2.20.2 Consultation with children and young people indicates that the sharing of information between agencies and the consequences that ensue are often a deterrent to accessing services. The NSPCC aims to offer children and young people a confidential space in which they feel able to openly discuss the problems they are experiencing and to discuss options that leave them feeling that their wishes and feelings have been respected and that they retain some control of events that directly involve them. Our ChildLine services and research clearly highlight the emphasis that children put on their information being kept confidential. For them it means "*if I tell you something, I expect you not to tell anyone else*"[xxiii] and it is a key criterion that children look for in choosing a person to talk to about their problems.

2.20.3 Where appropriate, the NSPCC works with children and young people to help them share information with relevant individuals and/or other agencies on the basis that this will help to ensure that they are safeguarded. The NSPCC also seeks to work in partnership with those who hold parental responsibility, unless this would be contrary to the best interests of the child/young person concerned.

2.21 Addressing professional concerns

Concerns have become evident in the Baby P case that different professionals were concerned about the decisions being made and at various times were trying to challenge them. A wider question for LSCBs is how is dissent managed and recorded at all stages from investigation, assessment, case conference through to legal planning. This needs careful consideration in terms of how one enables practitioners to take forward concerns if the internal mechanisms fail to resolve the issue adequately.

Q3. What specific actions should be taken by Government and national and local agencies to overcome these barriers and accelerate systematic improvements in safeguarding practice across the country?

3.1 Workforce: Competence; capacity; inter-agency working; systems of accountability

3.1.1 **A special Ministerial Task Force should be established reporting in Cabinet to identify the reforms needed to establish a safeguarding and protecting children from significant harm competence across the entire workforce that works with, or regularly comes into contact with, children and young people.** This taskforce will need to cut across the sectoral skills councils relating in particular to care, health and leisure. It will need to review the duties of Children's Trusts to ensure that appropriate workforce development and multi-agency training is provided locally to national requirements. It should address all of the workforce development recommendations in inspection reports over the last five years, and the recommendations set out in the overviews of SCRs and those of the Victoria Climbié Inquiry that have not been implemented.

If a task force were established many of the following recommendations would become part of its considerations. If not, they stand as set out.

3.1.2 **We recommend the production of an integrated workforce development and training programme and action plan for safeguarding children including, explicitly, their protection from significant harm.** This should form part of the Staying Safe Action Plan and the children's workforce development plans. It should also be informed by the training and workforce-related recommendations from serious case reviews and inspection reports. We note that a similar recommendation was made in the Victoria Climbié Inquiry Report and was never implemented.

3.1.3 **For the core workforce, professional qualifying training should be reviewed by a sub group to ensure that:**

- The curriculum prepares professionals for their child protection roles and responsibilities;
- It includes mandatory child protection elements, which are assessed;
- The content is up to date and fit for purpose;
- Training is delivered by educators with the necessary knowledge and practice experience; and
- It equips professionals to question the opinions of other professionals (Victoria Climbié Inquiry recommendations 37 and 100).

3.1.4 **Completion of the appropriate level of safeguarding training for paediatricians with three-yearly refreshers should be both mandatory and a requirement of professional registration.** New introductory training on child protection has been developed for paediatricians by the RCPCH and the NSPCC. More recently, the RCPCH, Advanced Life Saving Group and the NSPCC have developed an advanced level online training programme. This would fulfil recommendation 84 of the Victoria Climbié Inquiry.

3.1.5 **CORE-info materials should be widely distributed to all paediatricians to ensure they are familiar with the best available evidence on injuries to children.** The NSPCC and Cardiff University have published CORE information leaflets based on the systematic review of evidence in relation to physical injuries of children. This includes a new leaflet on spinal injuries directly relevant to the injuries experienced by Baby P.

3.1.6 **Continued professional registration for social workers and health professionals should be linked to evidence of completion of a minimum level of relevant specialist and continued professional development in safeguarding.** Currently it is not specified what training must be completed. This would require the development of a framework of learning outcomes for different roles and responsibilities (see below).

3.1.7 **A structured framework of continued professional development and competences for undertaking particular professional roles and responsibilities in relation to safeguarding children should be developed for each part of the core children's workforce.** This would build on the foundations of the common core of knowledge and skills. At present there is non-statutory guidance on learning outcomes for different professions and this could provide the basis of a progressive framework linked to registration and to the types of work someone is considered competent to undertake at different stages of professional development. This should fulfil a number of the recommendations of the Victoria Climbié Inquiry (eg recommendations 15, 20, 31, 39, 87, 90).

3.1.8 The Children's Workforce Development Council (CWDC) is currently piloting a structured framework of supported development for newly qualified social workers and for their next two to three years of practice. **This approach should be developed further to specify the competences relating to safeguarding responsibilities.**

3.1.9 **Continuing professional development for social workers and health visitors.** Practical micro-skills training is needed to assist workers in handling difficult situations – for example, weighing up cumulative evidence of risk in long-term cases, how to take a history, how to insist on seeing a child alone, how to work with resistant parents/children, how to check for injuries and when a medical opinion is required. This should be based on asking social workers what they find most challenging and should be delivered in the workplace by experienced practitioners.

3.1.10 **Allocated workloads should be appropriate to the level of experience, training and competence of the practitioner.**

3.1.11 **Supervision.** All those working with children at risk of serious harm should have access to professional advice and supervision by someone with the necessary knowledge and skills. Mentoring and peer support from experienced colleagues is a valuable supplement to formal supervision.

3.1.12 **There should be mandatory training on supervision for first line managers, which should cover not only general skills in supervising and managing staff, but also the in-depth knowledge and skills to make judgements and decisions in cases where there are child protection concerns.**

3.1.13 **There should be a specific module for those accountable for decision-making in relation to individual children that is focused on safeguarding children –** currently *Leading and Managing Children's Services in England – a national professional development framework* takes a broad approach to developing managers to meet all five ECM outcomes.

3.1.14 **LSCBs should be required to demonstrate that they provide a sufficient range and depth of training to meet the learning outcomes of different audiences as defined in the guidance issued with *Working Together to Safeguard Children* and, where necessary, to prepare an action plan for improving access to inter-agency safeguarding training.** The availability of inter-agency training is very variable and is linked to the resources allocated by different LSCBs to meet local needs. The NSPCC, through its Partners in Inter-agency Training (PIAT) programme supports a national network of inter-agency LSCB trainers. (More detail is provided in Appendix A)

Through this network we are aware that:

- Inter-agency training is seriously under-resourced in many places.
- At the current rate of progress in most areas it will take many years to provide all those in the core workforce with access to the inter-agency training specified in the *Working Together* guidance. In one area it was estimated that to provide multi-disciplinary training for all designated teachers would take approximately 60 years.
- There is limited access to training for those in the wider workforce.

3.1.15 **A more systematic review of needs in relation to work with children at risk of significant harm should be commissioned by the CWDC.** There are some **very positive examples of comprehensive and properly resourced training strategies,** including innovative programmes to reach the voluntary and community sectors. **These examples should be widely disseminated for example by Regional Government Offices or through the PIAT network.**

3.1.16 **Training needs to be accredited against agreed standards and learning outcomes. There is currently no agreed or national process for accrediting safeguarding training against agreed standards and learning outcomes. This should be explored in order to raise standards, and improve the consistency and transferability of learning.**

The wider workforce

3.1.17 Organisations need to **ensure that safeguarding is an element of the induction of all those in contact with children and families.** Guidance and materials are widely available now; the challenge is to make sure that employers are using these systematically and have processes in place for monitoring that this happens.

3.1.18 **There should be refresher training for the wider workforce every three years,** as there is for health and safety, recognising that these people will not routinely be seeing child protection concerns and awareness levels and vigilance will drop.

3.1.19 **It is important to ensure that those with designated safeguarding roles in voluntary and community settings have access to appropriate training to fulfil their roles.** The numbers requiring this training are enormous and many of these organisations have limited resources. LSCBs should ensure sufficient local provision for those in designated roles.

3.1.20 **Primary care trusts should be required by statutory guidance to ensure that child protection training is carried out in all GP practices at least once every three years.** This would fulfil Recommendation 87 of the Victoria Climbié Inquiry, which stated that all GPs should receive training in the recognition of deliberate harm to children. New introductory training on child protection has now been developed by the RCGP and the NSPCC for use in practices with the whole practice team. However, uptake of this training is optional and has been relatively slow.

3.1.21 **Schools should undertake whole-school training sessions at least every two years** on different aspects of safeguarding to maintain awareness and vigilance.

3.1.22 **Sport: a comprehensive safeguarding training and development strategy has recently been developed by the Child Protection in Sport Unit and this should be implemented with the necessary resources**.

3.1.23 **We need to create organisational cultures and processes that support staff and encourage critical questioning.** Retaining, developing and supporting experienced and skilled staff in practice is critical to the safety and wellbeing of children. Training and continuing professional development are only one part of this.

We should:

- Learn from good practice and organisations that are succeeding in retaining practitioners and managers;
- Use buddying and mentoring for newly qualified staff;
- Support joint/paired working both as a means of shared learning but also to help manage high-risk or complex, challenging, long-term cases;
- Use action learning sets and case discussions to promote shared learning;

- Provide casework supervision that encourages critical reflection on individual cases;
- Recognise, value and promote examples of good practice;
- Guard against a defensive retreat into excessive paperwork.

3.2 ContactPoint

3.2.1 **The NSPCC would like the UK Government to address the following concerns about the operation and effectiveness of ContactPoint.** The current system may miss out vulnerable children if it does not include those brought into the UK by people who are not their legal guardians or who are in the UK temporarily and cannot be describe as "ordinarily resident". These children and young people enter the country for a variety of reasons, and may be:

- Children and young people unaccompanied and seeking refuge or asylum;
- Children and young people accompanied by a relative or guardian;
- Children and young people who may appear to be accompanied but are actually not accompanied by a parent or guardian; or
- Children and young people who are not resident, or expected to remain for under 3 years.

3.2.2 **The NSPCC strongly urges the Government to support the development of appropriate systems in all UK nations and ensure that these systems are compatible across UK borders.** Under the current arrangements, ContactPoint will only provide information about children living in England. This will result in children who move to Wales, Scotland or Northern Ireland having an incomplete record. It is vital that any IT solutions being developed in the devolved administrations should be able to exchange relevant information about a child, and thus have "inter-operability".

3.3 Leadership and accountability

We recommend that an understanding of the safeguarding agenda including child protection should be mandatory and built into the leadership courses provided for senior managers across the public sector. We support the five point plan set out by LGA at their summit, which includes:

- A programme on child protection and safeguarding that gives councils access to the best possible advice;
- Ofsted to discuss with councils how it can affectively assess the quality of child protection practice and support councils and others in service improvement;
- Improving links between child protection and the care system.

Professional and regulatory bodies also have a role to play in ensuring that the competences they set for practitioners and managers adequately cover the safeguarding issues for both children and vulnerable adults. We question whether

their powers are sufficiently robust to ensure the competence of their members, to act effectively in cases of incompetence or malpractice and to defend child protection work, which can be challenged by individuals and the media.

3.4 Assessment

We recommend that ministers review the Common Assessment Framework (CAF) and the ICS in the light of criticism that risk is not a core focus, and criticisms about paperwork and bureaucracy. We also recommend that the DCSF monitor the implementation of the CAF and review its effectiveness by 2011.

3.5 Thresholds

There should be a collaborative approach, both across services and with government, on tackling the issue of thresholds, and we call for national guidance to be published by LGA, the NHS Confederation and government on this issue. There are interesting developments in some Scottish authorities on addressing this issue that may merit consideration.

3.6 Listening to the child

We recommend that consideration should be given to a statutory duty requiring that **all children who are the subject of a Section 47 investigation or a child protection plan must, if practicable and reasonable in the circumstances, be seen alone by appropriate professionals.**

3.7 Resources

There is a need to establish whether local authorities and primary care trusts are spending enough of their budgets on services for children in need and children in need of protection in order to discharge their statutory duties. We support the LGA call for **"***for increased investment in children's social work in the medium term to ensure councils can recruit and train the best possible people. In the shorter term we propose changes to the structure of children's services funding to help councils employ more children's social work staff"*.

3.8 Inspection

We consider that it would be timely to undertake a high level review of Ofsted's inspection methodology, and the extent at which it is able to "get into the corners" of the quality of safeguarding delivery. We think that Ofsted needs to ask different questions of LSCBs and children's services departments in order to do this. The NSPCC would be pleased to help devise the questions and the methodology.

3.9 The Public Law Outline

There is a need for proper evidence of the cause and effect of decisions being taken regarding care applications since the introduction of the PLO and the increased fees. We very much hope that you will address this as part of your review.

3.10 Section 20

We would recommend that a review be undertaken on how the use of Section 20.

3.11 Familial homicide

The NSPCC recommends that the familial homicide charge should be extended to include causing or allowing the *serious injury* of a child.

3.12 Equal protection

There should be no defence for parental use of physical punishment. The law should give professionals working with children and families a clear mandate for promoting positive parenting and for being clear that physical punishment can be harmful.

3.13 LSCBs

3.13.1 **We would recommend that the chairs of LSCBs should be independent. In due course it would be important to set out a person specification that should be used for the recruitment and appointment of LSCB Chairs.** Appropriate ongoing support and training should also be provided for LSCB Chairs, to assist them in sharing learning and to strengthen their contribution to safeguarding children and young people.

3.13.2 **The government should set out a clear formula for appropriate resourcing of LSCBs, to enable them to fulfil their remit, and to ensure consistency across the country.**

3.14 SCRs

3.14.1 **We welcome the Secretary of State's direction that SCRs currently marked as inadequate should be revisited and chaired by someone with suitable experience who is independent of all the organisations involved. We would recommend that an independent Chair should be the normal requirement for all SCRs.**

3.14.2 **We recommend that all SCR executive summaries be published by Ofsted or the DCSF on their websites.** While guidance is clear that an executive summary should be published, we are aware that this does not always happen; neither is it easy to access such documents.

3.14.3 **We recommend that Ministers should be required on a biennial basis to report to Parliament with a review of learning from SCRs and Child Deaths and set out how each relevant Whitehall department, not only the DCSF, will be responding to recommendations that fall within their competence.**

3.15 Child Death Overview Panels

3.15.1 **The NSPCC recommends that Child Death Overview Panels (CDOPs) must be explicitly required when reviewing child deaths to consider whether abuse or neglect contributed to the death and record this in the review notes.**

3.15.2 **There should be a national strategy for reducing the number of child deaths from abuse and neglect.** To help achieve this, child death overview panel data should, in accordance with paragraph 7.57 of *Working Together to Safeguard Children,* be collated by individual panels and submitted to bodies (such as, we suggest, the Office of National Statistics) to enable annual national aggregation of the figures.

3.15.3 **We further recommend that the Government (in partnership with the devolved Parliament in Scotland and the Assemblies in Wales and Northern Ireland) should use the data provided by CDOPs to monitor the achievement of the preventable child deaths element of Public Service Agreement 13** and develop a national strategy for reducing the number of child deaths from abuse and neglect.

3.17 Specific groups

3.17.1 **This needs considerable extra resources. The number of health visitors therefore needs to be increased rapidly to provide a basic universal service.** There must be sufficient highly qualified reflective practitioners who are confident and skilled in working in partnership with families as well as assessing a child's needs.

3.17.2 **As a society we need to move from a culture of fear to one of support for children, parents and professionals. Professionals need confidence in their abilities to work alongside parents and comprehensively assess risk.** No tools are foolproof and mistakes may be made but a constantly reflective dialogue with parents and within supportive teams is necessary to help ensure that children's wellbeing is prioritised in all actions. Helping parents themselves to learn to be reflective (or mindful) is an important part of the work done in Infant Mental Health. To be able to do this requires a reflective space for the professional in which to discuss difficult feelings that the work raises and to think about them.

3.18 Neglect

The DCSF should revise *Working Together to Safeguard Children* and *What to do if you're worried about a child* to remove the terms "persistent" and "long term" and replace them with a clear timelines to promote improvement in care, such as: "*if following the provision of services for a child by agencies for an agreed time period the child's health or development is still judged likely to be significantly impaired by remaining within their current care setting it may be appropriate to take action to remove the child from their family.*"

3.19 Deaf and disabled children

3.19.1 **There should be a DCSF-led review of how well deaf and disabled children are safeguarded,** in order to address the significantly increased risk of abuse to these children and the barriers that continue to exist within the child protection system. This should include:

- data collection and analysis of disabled children who are subject to the child protection process;
- a review of existing local and inter-agency mechanisms to promote safeguarding of disabled children;
- a review of child protection processes in respect of disabled children placed in residential special schools;
- a review of civil and criminal proceedings;
- a review of Serious Case Reviews where the child was disabled.

3.19.2 **LSCBs should review local procedures** and **policies and training programmes should be reviewed to ensure that the needs of deaf children are recognised and can be met.** This would fulfil one of the key recommendations of the TEA report, *Mental Health and Deafness Toward Equity and Access – best practice*.

3.20 Confidential space

We recommend that the DCSF initiates a widespread professional debate about levels of confidentiality for children's services providers, given their now recognised preference for confidentiality with professionals who they can trust. It may be timely to consider the provision of a "mixed economy" of service offering differing levels of confidentiality in order to increase children's choices and increase the likelihood of them seeking help when they are being abused.

3.21 Addressing professional concerns

We recommend that practitioners should have clear routes to raise issues of poor practice or inappropriate decision-making, especially if they have exhausted all internal routes for reconsidering decisions. Consideration could be given to establishing an independent advice line for professionals.

3.22 Government and devolved nations

The devolved nations and UK government should maintain a regular dialogue and actively collaborate to ensure a) that disparities in legislation or policy do not inhibit good child protection practice and b) that good child protection practice is shared across the four nations of the UK. We have, with support from the DCSF and devolved administrations, set up the Centre for Learning in Child Protection (CLiCP) based at Edinburgh University which has the aim of enabling learning to be shared across the UK.

APPENDIX A

Q1. What good practice has been successfully achieved in safeguarding children since the publication of the Victoria Climbié Report?

NSPCC Training and Consultancy

1. Effective implementation of safeguarding systems and procedures

Safe Communities Toolkit
This is a major three-year initiative to enable community-based organisations to play their part in keeping children safe. A toolkit has been produced including information for parents and children; an awareness-raising video to use with volunteers, parents and children; training materials, and guidance on how to run a safe organisation. This is available in six different languages. A pilot has been run in three areas taking a community-based capacity building approach to engage small community organisations and to build bridges with the statutory sector. This whole programme has been evaluated. The project has supported over 4,500 organisations to put safeguarding systems and processes in place.

Staying Safe Commitment Scheme
This scheme provides recognition and support for organisations that have taken initial steps to introduce measures to protect children from harm. It is underpinned by the NSPCC's Safetycheck standards, which have ministerial endorsement. The scheme is open to voluntary, community and commercial organisations and provides information, help and support plus an assessment of an organisation's policies and procedures. Sixty organisations have registered since the scheme was launched in 2006 and feedback from organisations that have completed the process demonstrates that significant improvements have been made.

Safeguarding Standards for Sport
The Child Protection in Sport Unit supports sports governing bodies and county sports partnerships to nine safeguarding standards. Meeting the standards is linked to receiving funding from Sport England. Ninety-one organisations so far have met the preliminary standards and 60 have achieved the intermediate standards. This standards-based approach has acted as a powerful driver for change across the sporting sector.

Safeguarding Quality Improvement Tool for Schools
This is a web-based self-assessment tool, supported by guidance and resources, to enable all schools to audit and improve their own performance, which we are piloting in January 2009. There has been extensive consultation on the standards and the approach with schools, children and other key stakeholders during its development. The standards cover: promoting emotional health; wellbeing and safety; keeping safe from bullying; child protection; safety outside the classroom

and governance and safer staff. The tool helps schools identify where further work is needed to improve safeguarding and to develop an action plan.

The NSPCC and Ide&A worked with a number of Local Authorities and their lead members to develop **Signposts** - an interactive CD Rom to assist Lead Members and Directors of Children's Services to review the effectiveness of their safeguarding arrangements.

2. Inter-agency working

Piat is partnership between Sheffield University, Nottingham University and the NSPCC to promote and support the development of high quality inter-agency safeguarding training and the development of an inter-agency trainers network. There is usually only one inter-agency training coordinator in each LCSB working in relative isolation, often bearing huge responsibilities and expectations. Piat helps to connect these posts and shares best practice and learning through an annual Symposium. The network provides unique insights into the strengths and challenges of inter-agency training. Induction events for newly appointed LSCB inter-agency training coordinators are run annually. This year Piat has published *Make A Difference* – an interactive tool for reviewing two key areas: the effectiveness of inter-agency safeguarding training and the quality of inter-agency relationships.

Safeguarding Children – a shared responsibility

Following the Victoria Climbié Inquiry, the DCSF commissioned the NSPCC and a consortium of organisations to develop inter-agency training programmes on safeguarding children. These programmes have three different levels, supported by a reader, and a DVD has been published. They are being extensively used by LSCBs for inter-agency training. The programmes include material on getting the basics right and on information sharing.

3. Development of a professional workforce

The NSPCC has worked with others to develop a number of products to support the development of the professional workforce. We have listed a selection of these below which are of particular relevance to this Review.

Training for paediatricians

Working with the Royal College of Paediatrics and Child Health and the Advanced Life Saving group we have developed introductory training on child protection for paediatric registrars. This consists of assessed face to face training supported by information on a CD. A more advanced training programme, using a virtual learning environment, is in the final stages of development and will be for use by paediatricians. ALSG trains and accredits trainers to deliver the face to face course and this is being rolled out through centres around the country. The challenge now is to make this training more widely available and to make it a mandatory requirement.

Training for general practices
Working with the Royal College of General Practitioners we have developed materials to run whole practice training sessions on child protection. These can be downloaded from the RCGP website.

CORE info leaflets
The Welsh Systematic Review Group based at Cardiff University has undertaken a series of systematic reviews of evidence of different types of physical injury of children. The NSPCC distils the key learning into short leaflets to assist practitioners to apply the best available evidence in their practice. The leaflets published to date cover: fractures, burns, non-accidental head injuries, abdominal injuries and oral injuries and bites. We will shortly be publishing a leaflet on spinal injuries. They are available on our website at **http://www.nspcc.org.uk/Inform/trainingandconsultancy/learningresources/coreinfo/coreinfo_wda54369.html**

The Developing World of the Child
The DCSF commissioned the Open University and the NSPCC to develop a training resource and reader for practitioners on assessing children's developmental needs. It is designed for use in practice, supervision and face to face training and includes a practice workbook and poster.

EduCare
A series of modular distance learning programmes on different aspects of safeguarding have been developed and independently evaluated. These programmes are assessed and certificated. They are available in hard copy and online and more than 150,000 people have successfully completed the training. The NSPCC requires all non-social work qualified staff to complete one of these programmes as part of their induction programme. Ofsted require all their staff to complete a specially tailored EduCare programme on child protection. The NHS has put the programme on their website but has so far not made it mandatory for all new employees to complete this. Where it is built into induction programmes it provides an essential basic introduction to child protection. A refresher programme is about to be launched. The evaluation results are exceptional and can be made available to the Review.

4. Effective systems of public accountability

Safeguarding through audit
This guide provides agencies and LSCBs with a method of conducting self-audits of serious case review recommendations and can also be used for wider auditing purposes. It offers a practical guide to framing recommendations and ensuring that these are linked to action plans.

APPENDIX B

NSPCC Services for Children and Young People

The Cardiff Domestic Violence Abuse Service tackles the issue of violence in the home. The strong links between domestic violence and child abuse led to the development of the service which works with children and young people who are at risk from the direct and indirect effects of domestic violence in order to reduce the impact that their experiences have on them. The project also runs the Caring Dads project which provides assessment and intervention programmes for the parent/carer who is the victim of the violence as well as for the perpetrator of the abuse. Individuals work as part of a group or on a one-to-one basis. The project offers training and consultation to professional groups on all aspects of domestic violence.

The Parkside Assessment Project works in partnership with the Central and North West London Mental Health Trust using a range of models including psychodynamic and systematic family therapy models. All work is based on knowledge of normal child development and the impact that abuse, neglect and trauma can have on children. Specialist multi-disciplinary family and parenting assessments are provided for court proceedings or where decisions need to be made about a child's care in cases where the child's welfare and safety are of serious concern. Reports are produced for the court, which include overall assessment of the family and parenting, as well as in individual needs assessment for each child. The project also offers consultation where there are complex abuse and neglect issues affecting the child, the family and the professional system.

The Bal Raksha Project offers family support services to Asian communities. The project receives referrals directly from service users as well as professionals from other agencies such as social care, education and health, other voluntary agencies and community groups. The project offers a range of services to local parents and their children through project-based services and community outreach programmes. These services include drop-ins, play schemes, parenting programmes and one-to-one work with children and families. Families are also seen within their home environment and parenting programmes are delivered in a variety of settings to suit individual needs. By working closely with the local media the project helps to raise awareness of abuse and protect children from harm. New areas of work that are being developed include:

- An outreach service in four local schools;
- Group work with single parents;
- Domestic violence work;
- A toy library.

The NSPCC Bristol and Somerset Schools Team provides a counselling, support and advisory service. The service is provided to children, young people and adults in designated schools within Bristol and Somerset, by providing a counsellor/therapeutic social worker in school one or two days per week, in term time. The service offers a package to schools which includes child protection awareness training, direct work with children and consultation and advice to the adults in the school.

Children and young people have the opportunity to receive individual, peer and small group counselling as well as more general advice and support. Specific issue group work is also undertaken in designated schools where issues have arisen either through the counselling advice and support work or at the request of the school. For example, disability inclusion and emotional resilience are two general topics which the team has worked on recently. Where appropriate, children and young people are offered a continuous service throughout the school holidays.

The service is provided mainly on a self-referral basis, although there are also assisted referral and direct referrals from school staff, family members and other professions. At times, members of the public drop in to the office with child protection related concerns. The helpline details are given and where necessary a duty service is provided in order to safeguard children. Currently the team provides a service to eight senior schools (including a special needs school) across Bristol and Somerset. The team also works in two junior schools in Bristol which includes working with parents/carers.

The Bfree and Street Matters Projects are based in East London and work with young women up to 18 years of age around issues of sexual exploitation, including abuse through prostitution. Both projects offer a mix of individual work, group work and outreach, as well as providing training to professionals. Bfree offers support to young women found in the west end of London, including emotional support, raising awareness around risk, advocacy and practical assistance. Bfree works in partnership with Social Services, the police and other voluntary organisations.

The York Therapeutic Team provides a therapeutic service for children who have been abused. It uses a range of different approaches and creative therapies to help children come to terms with what has happened to them. The team also runs support groups for couples and for carers of children who have been sexually abused.

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