

**NSPCC response to the pre-consultation paper issued by the National
Safeguarding Delivery Unit: Responding to Lord Laming's
recommendations on *Working Together to Safeguard Children***

1. Introduction

The 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 in the UK over future generations. In pursuit of our vision we will:

- create and deliver services for children which are innovative, distinctive and demonstrate how to enhance child protection most effectively;
- provide advice and support to ensure that every child is listened to and protected;
- provide advice and support to adults and professionals concerned about a child and if necessary take action to protect the child;
- work with organisations which work with children to ensure they effectively protect children and challenge those which do not;
- campaign for changes to legislation, policy and practice to ensure they best protect children;
- persuade everyone to take personal responsibility for preventing cruelty to children;
- inform and educate the public to change attitudes and behaviours towards children;
- use our statutory powers as necessary to protect children.

2. General comment on the revision of *Working Together*

We are concerned that the pre-consultation paper considers only Lord Laming's recommendations; further, it considers a narrower selection of them than we regard as necessary for improving child protection guidance.

We consider the revision should also be attentive to the conclusions and recommendations of a number of other reports, including:

- *The Independent Review of Restraint in Juvenile Secure Settings* (Peter Smallridge and Andrew Williamson, December 2008)
- *Keeping our School Safe: Review of Safeguarding Arrangements in Independent Schools, Non-Maintained Special Schools and Boarding Schools in England* (Sir Roger Singleton, March 2009)
- *Report to the Secretary of State on the Review of Elective Home Education in England* (Graham Badman, June 2009).

The apparent scope of the revision is also inattentive to evidence concerning disability. Some issues with respect to disabled children, disabled parents and adults with learning difficulties were identified as weaknesses in the most recent Ofsted Evaluation of Serious Case Reviews, *Learning Lessons: Taking*

actions. These warrant attention and referencing in the redraft of *Working Together*. In particular there is a need for:

- more consistent assessment of need for disabled children and young carers who may be looking after a disabled parent;
- more training to increase the understanding and ability of those who work with disabled people to take into account both disability and child protection issues;
- better communication and information-sharing across adult and children's services, for example when there are child protection concerns in families in which the children have caring responsibilities for disabled parents;
- better assessment of the impact of the learning difficulties of adults on their capacity as parents and on their own mental health.

3. The choice of recommendations

In this section we provide comment on the recommendations in Lord Laming's report, by the number in that report, which we consider should have additionally been included in this pre-consultation paper. Lord Laming's recommendations are italicised, and are followed by our view of their pertinence to this paper:

- **8.** *The Department for Children, Schools and Families should organise regular training on safeguarding and child protection and on effective leadership for all senior political leaders and managers across frontline services.*

While leadership training is referenced in this paper, as a response to recommendation 7, there is no reference to regular training on safeguarding and child protection for political leaders and managers. We understand, through other discourses, that this will be addressed in the revision of chapter 4, but it would be helpful if this commitment were explicit in the response to this pre-consultation.

- **10.** *Ofsted should revise the inspection and improvement regime for schools, giving greater prominence to how well schools are fulfilling their responsibilities for child protection.*

The guidance should signpost the new school inspection framework which has applied since September, and which the government's Action Plan (*The protection of children in England* – May 2009, hereafter referred to as the government's Action Plan) asserts will 'raise the bar about the importance of safeguarding for schools and will also facilitate the identification and dissemination of best practice'.

- **12.** *The Department of Health and the Department for Children, Schools and Families must strengthen current guidance and put in place the systems and training so that staff in Accident and Emergency departments are able to tell if a child has recently presented at any Accident and*

Emergency department and if a child is the subject of a Child Protection Plan. If there is any cause for concern, staff must act accordingly, contacting other professionals, conducting further medical examinations of the child as appropriate and necessary, and ensuring no child is discharged whilst concerns for their safety or well-being remain.

Guidance to A and E staff is core to the purpose of *Working Together*. The government's Action Plan states that the government will work with both the College of Emergency Medicine and the Department of Health Informatics Directorate 'and co-ordinate this work with our broader look at safeguarding training of health professionals and with the government's revision of *Working Together...*' This commitment needs to be fulfilled.

- **21.** *The National Safeguarding Delivery Unit should urgently develop guidance on referral and assessment systems for children affected by domestic violence, adult mental health problems, and drugs and alcohol misuse using current best practice. This should be shared with local authorities, health and police with an expectation that the assessment of risk and level of support given to such children will improve quickly and significantly in every Children's Trust.*

This recommendation is important. Guidance needs to be attentive, for example, to the well evidenced and detrimental effects of cumulative referrals, and the high risk attached to withdrawing support once adults have separated.¹ If the response to this recommendation has been conflated with the response to recommendation 20 about referral processes in adult services then this should be made explicit. This does however weaken it. If the guidance on referral and assessment systems which the government's Action Plan identifies as an early priority is not to be sited in *Working Together* then it would at least benefit from being referenced there.

4. Response to the recommendations

In this section we respond to the questions raised in the pre-consultation paper. We are asked:

- a) What are your views on the proposed treatment of each of the...recommendations [below]?
- b) Do you have alternative suggestions on how best the government should respond in *Working Together...* to these recommendations?

Recommendation 6

Directors of Children's Services, Chief Executives of Primary Care Trusts, Police Area Commanders and other senior service managers must regularly

¹ Stanley, Nicky, and Miller, Pam, and Foster, Helen Richardson, and Thomson, Gill (2009) Children and families experiencing domestic violence: police and children's social services' responses. London, NSPCC.

review all points of referral where concerns about a child's safety are received to ensure they are sound in terms of the quality of risk assessments, decision making, onward referrals and multi-agency working.

The treatment of this recommendation proposed in the pre-consultation document is coherent, but does not address the core issue explicit in the recommendation, namely the responsibility of the senior manager.

However thresholds are determined (be they locally driven, made nationally explicit in guidance, or subject to regional protocols such as those that are pan-London), the responsibilities of the senior manager for thresholds must be made explicit.

There needs to be a prompt to advise voluntary and community sector providers of the thresholds that are operating. The sector is evidenced by the University of Hull's recent audit,² as a major, and often the majority, provider of services to children and young people in any given locality.

Recommendation 7

All Directors of Children's Services who do not have direct experience or background in safeguarding and child protection must appoint a senior manager within their team with the necessary skills and experience.

Recommendation 7 is not being fully addressed, in that no reference is made in the proposed treatment to the appointment of a senior manager.

However, this requirement is explicit in the guidance on *the roles and responsibilities of the lead member for children's services and director of children's services*.

We suggest it is important clearly to emphasise the requirement to appoint a senior manager in *Working Together*.

Recommendation 9

Every Children's Trust should ensure that the needs assessment that informs their Children and Young People's Plan regularly reviews the needs of all children and young people in their area, paying particular attention to the general need of children and those in need of protection. The National Safeguarding Delivery Unit should support Children's Trusts with this work. Government Offices should specifically monitor and challenge Children's Trusts on the quality of this analysis.

² Craig, Gary, and Gibson, Helen, and Perkins, Neil, and Wilkinson, Mick, and Wray, Jane (2008) Every organisation matters: mapping the children and young people's voluntary and community sector. London: National Council of Voluntary Child Care Organisations and National Council for Voluntary Youth Services.

The response to this recommendation is welcome, though a bi-annual report from the LSCB may fit better with other processes and planning arrangements than an annual one. Feedback from our staff on LSCBs suggests that a two-year cycle for reporting would be more manageable and allow for change to be implemented and reported on more effectively than an annual cycle.

Annex B of the pre-consultation document – ‘the relationship between the LSCB and the Children’s Trust Board’ - clearly provides context to this response, and we assume will inform the substantive text. However, while Annex B describes the LSCB as ‘primarily a scrutiny body’, it is less attentive to its role in challenging Children’s Trusts. The government’s Action Plan emphasises the stress that Lord Laming placed on ‘a clear distinction between the roles and responsibilities between LSCBs and Children’s Trusts to ensure appropriate **challenge** *[our emphasis]*, scrutiny and impartiality’. The challenge function should not be diluted, as it seems to be, by the more collaborative understanding advanced in the Annex.

It is difficult to achieve a balance between ensuring the challenge that prompts key agencies to maintain their focus on the needs and rights of children at risk of harm, and enabling the joint enterprise that delivers effective working together.

The developmental function of LSCBs, particularly with respect to training, also needs to be valued and effectively resourced. Research by Carpenter et al (2009)³ shows that LSCBs are delivering very effective training but are under resourced. We suggest this under resourcing is rooted in a lack of clarity as to responsibility for the delivery of inter-agency training, and urge the NSDU/DCSF to make this responsibility explicit in guidance, including training provided the voluntary and community sector.

Recommendation 11

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

The expressed intention to take into account the recommendations of the Social Work Task Force is welcome. The ‘licence’ recommended in their report is particularly pertinent. While likely to be an idea that is insufficiently developed to inform the current revision of *Working Together*, we urge that it is not lost sight of in any subsequent revisions.

³ *Organisation, outcomes and costs of inter-agency training for safeguarding and promoting the welfare of children*, Carpenter, John et al, DCSF, 2009

Recommendation 13

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

There is a risk of diluting the effect of Lord Laming's recommendation that all assessments... must include direct contact with the child. In our reading, the proposal is that chapter 5 will be revised 'to include specific reference to the child being seen alone, **where appropriate...**' [*our emphasis*]. Framed in this way the guidance places the onus on the worker to find cause to see the child alone. We would rather see guidance framed so that there is a clear expectation of seeing the child and that the reason for not seeing a child alone is recorded.

Assessment would fall short of being comprehensive if the references to domestic violence, mental ill health, substance misuse etc. (which we strongly welcome), were, as indicated in the proposed treatment, listed as 'difficulties' without exploration of their relationship to the physical care of children, neglect and sexual harm. It is the interplay of such factors with parenting that needs to be at the heart of a good systematic assessment and under the guidance there is a danger that practitioners may tick these factors off on a list and not systematically analyse any impact they have on the child's welfare and the carer's ability to protect and care for the child

We consider that Lord Laming's exposition of this recommendation is as significant as the recommendation itself. He points out that a **child-centred** [*our emphasis*], sensitive and comprehensive assessment is fundamental to establishing the extent of a child's need. We would emphasise that Ofsted's 2008 review of serious case reviews confirms many earlier studies that the children whose lives and deaths are being reviewed were in far too many instances not seen, heard or listened to by the adults investigating, and charged with the responsibility of ensuring, their safety and wellbeing.

The child-centred nature of assessment is in our view the major element of this recommendation needing to be addressed in guidance. It remains important, however, in achieving this that the initial and core assessment should explicitly consider whether behaviours exhibited by the carers or children could be influenced by domestic violence, mental ill health or any of the other factors rightly emphasised in the proposed treatment of Lord Laming's recommendation.

We would add that, in assessing the child's environment, it is necessary to include 'significant others' who are connected to the family while not being members of the household; the frequency of their visits, contact with and access to the children.

Recommendation 14

Local authorities must ensure that 'Children in Need', as defined by Section 17 of the Children Act 1989, have early access to effective specialist services and support to meet their needs.

We agree without reservation with the proposed treatment of this recommendation.

Recommendation 16

The Department for Children, Schools and Families should revise Working Together to Safeguard Children to set out the elements of high quality supervision focused on case planning, constructive challenge and professional development.

The phrase 'high quality supervision' requires explicit definition. We regard 'high quality supervision' to be supervision undertaken by someone experienced, and to be regular, planned, challenging and reflective. We are confident that the revision of chapter 4 will be attentive to the advice, and report, of the Social Work Task Force in this respect.

Recommendation 19

The Department for Children, Schools and Families must strengthen Working Together to Safeguard Children, and Children's Trusts must take appropriate action to ensure that:

- *All referrals to children's services from other professionals lead to an initial assessment, including direct involvement with the child or young person and their family, and the direct engagement with, and feedback to, the referring professional; core group meetings, reviews and casework decisions include all the professionals involved with the child, particularly police, health, youth services and education colleagues. Records must be kept which must include the written views of those who cannot make such meetings; and*
- *formal procedures are in place for managing a conflict of opinion between professionals from different services over the safety of a child*

We are very concerned about the proposed treatment of this recommendation. It does not address the core issues of direct engagement with and feedback to the referring professional, nor does it reference the need to establish formal procedures to manage a conflict of professional opinion.

Recommendation 20

All police, probation, adult mental health and adult drugs and alcohol services should have well understood referral processes which prioritise the protection

and well-being of children. These should include automatic referral where domestic violence or drug or alcohol abuse may put a child at risk of abuse or neglect.

We agree with the proposed treatment of this recommendation.

Recommendation 22

The Department for Children, Schools and Families should establish statutory representation on Local Safeguarding Children Boards from schools, adult mental health and adult drug and alcohol services.

This recommendation has been dismissed too lightly with respect to statutory representation on LSCBs from adult mental health and adult drug and alcohol services, given Lord Laming's emphasis in the relevant section of the body of his report that the 'answer must lie in joint working between police, health and social services'. The government's response in the Action Plan – that this is to be reflected in *Working Together* - is also overturned. The reason advanced for making no change is that NHS Trusts are already represented on LSCBs. However this representation may well be at too high a level, or members' responsibilities may be drawn too widely, and in such cases Lord Laming's aspiration cannot be fulfilled through this representation.

School representation is complex; schools constitute a rich diversity of communities and priorities. There is at least a case for differentiating between primary and secondary schools. There is a case too for looking at ways of ensuring that those headteachers attending the LSCB are fully briefed by their colleagues, perhaps through local 'surgeries' feeding in to an annual general meeting – a method currently being considered by some LSCBs as ensuring a wider representation of the voluntary and community sector in their area.

Recommendation 23

Every Children's Trust should assure themselves that partners consistently apply the Information Sharing Guidance published by the Department for Children, Schools and Families and Department for Communities and Local Government to protect children.

We are in full agreement with the proposed treatment of this recommendation.

Recommendation 25

Children's Trusts should ensure a named, and preferably co-located, representative from the police service, community paediatric specialist and health visitor are active partners within each children's social work department.

We are in complete agreement with the proposed treatment of this recommendation.

Recommendation 29

Children's Trusts should ensure that all staff who work with children receive initial training and continuing professional development which enables them to understand normal child development and recognise potential signs of abuse or neglect.

Although the treatment of the recommendation is coherent and consistent with the recommendation in itself, we disagree with the stress on normal child development within the recommendation, and therefore with the strand of the proposed treatment that reflects that emphasis. We consider that the guidance should focus on understanding child development within the context of the individual child, including disabled children and those with complex needs.

Recommendation 30

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

We agree with the proposed treatment of this recommendation.

Recommendation 51

The Children's Trust and the Local Safeguarding Children Board should not be chaired by the same person. The Local Safeguarding Children Board chair should be selected with the agreement of a group of multi-agency partners and should have access to training to support them in their role.

We agree with the proposed treatment of this recommendation, and particularly welcome the attentiveness to training needs, but, given the local authority's role as employer, we consider that a more robust process needs to be advanced to ensure the chair's independence is upheld at appointment and thereafter.

Recommendation 52

Local Safeguarding Children Boards should include membership from the senior decision makers from all safeguarding partners, who should attend regularly and be fully involved as equal partners in Local Safeguarding Children Board decision making.

We agree with the proposed treatment of this recommendation

Recommendation 53

Local Safeguarding Children Boards should report to the Children's Trust Board and publish an annual report on the effectiveness of safeguarding in the local area. Local Safeguarding Children Boards should provide robust challenge to the work of the Children's Trust and its partners in order to ensure that the right systems and quality of services and practice are in place so that children are properly safeguarded.

We agree with the proposed treatment of this recommendation.

5. The protection of Children in England: Action Plan

We consider that lay involvement in LSCBs would most efficiently be effected by engagement with the local community sector, a major and often majority provider of services to children in any given community, and with the volunteers and parents providing services from playgroups to youth clubs, rock climbing to embroidery; as was exemplified by the NSPCC's Big Lottery funded *Safe communities* project between 2006 and 2009. Councils of voluntary service may have a useful role to play here.

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