

To: (i) Cabinet, 29 March 2010;  
(ii) Vulnerable Children Policy Overview & Scrutiny Committee - 31 March 2010;  
(iii) County Council, 1 April 2010

By: The Chief Executive

Subject: Safeguarding children in Kent: Defending and Developing the Service

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Summary: the report marks the final stage of the review commissioned by the County Council in December 2008, to be undertaken by the Chief Executive, of the arrangements in Kent for protecting vulnerable children. It gives an overview of the Review Team's assessment of arrangements in their local and national contexts and sets out a number of recommendations for consideration by the County Council.

#### FOR DECISION

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1. This report marks the final stage of the review commissioned by the County Council in December 2008. Previous written reports have been presented to the Children's Champions Board in February and July 2009 and these have been supplemented by verbal reports to that Board in May 2009 and March 2010. The Chief Executive and his Review Team thank the Children's Champions Board, and the Chairman, Ann Allen in particular, for their continued keen interest and their enthusiasm and support for taking this forward over the last 16 months.

2. Protecting vulnerable children is a critical responsibility for the County Council with its 'corporate parent' responsibilities and so the Chief Executive and his Review Team are pleased to be able to present their report to Cabinet and the Vulnerable Children Policy Overview & Scrutiny Committee for discussion and comment, en route to full Council, who initially commissioned it.

#### Recommendations to the County Council

3. The County Council is asked to:
- (a) note the contents of the report;
  - (b) consider its response to the recommendations set out in the report; and
  - (c) decide how it would wish to take forward its responses to the report and the recommendations.

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Previous committee references – Children's Champions Board, 12 February 2009; 20 May 2009; 21 July 2009, 10 March 2010.

Background documents – relevant reports are cited and referenced throughout the main body of the report.

**Safeguarding children in Kent: defending and developing the service**  
**Foreword by the Chief Executive, Peter Gilroy OBE**

*It is hard to imagine a service provided by public services more critical than that of protecting vulnerable children. In Kent, the County Council plays an absolutely pivotal role and I think that, despite the high stakes of the very occasional – and virtually inevitable - failure, we should be proud of the responsibility we have and the competent way we go about meeting that responsibility.*

*Most of all, we should give our whole-hearted support to those professional practitioners, their supervisors and support staff, who carry the burden of that responsibility day to day on our behalf. Being a Social worker with child protection responsibilities is without doubt one of the most difficult high risk occupations in the public sector. As we know from recent events, even when a single human error is made, it can have tragic consequences. It is at times like these we need to be most supportive as well as publicly standing up to be held to account where systemic failure or professional incompetence or negligence are the causes.*

*We – all of us - need to bear in mind that social workers are dealing with complex, dysfunctional and at times dangerous individuals and families. It is not a job for the faint-hearted – it requires a sound value base and personal resilience. It is not just about social workers. Fieldwork staff – and this must include police colleagues and health visitors – are best served by continuity and sound working personal relationships as it is this group who are needed 24/7 for this high risk work. It is not covered in detail in this report but over-regulation, rather than protect children, may well have the unintended consequences of diminishing individual and family responsibility and sound professional judgement.*

*I am pleased to commend my report and its recommendations to the County Council for its consideration. It portrays a service that is just about coping with some difficult pressures but with its morale intact. My recommendations about how arrangements might be improved, as befitting my professional background as a social worker, are offered as those offered by a critical friend. Preparing this report has, of course, relied on the assistance and goodwill of many colleagues and agencies including academic colleagues from Christ Church and Kent Universities, to whom I offer thanks on behalf of myself and my fellow reviewers, Peter Thomason and Martyn Ayre.*

*It is always invidious to single out individuals but in particular, our thanks go to Joanne Purvis in the Corporate Performance Management Team for her sterling work during the critical early stages of the review; to Ann Allen as Chairman of the Children's Champions Board for her support and sponsorship throughout; to Penny Davies, the Kent Safeguarding Children Board Manager and Kay Weiss and her team in Children, Families & Education for their unstinting efforts in providing information – and advice!*

**Safeguarding children in Kent: defending and developing the service.**

**Report to County Council, 1 April 2010**

**Executive Summary**

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*“.....the job social workers do is critical to the nation. They play an essential role in protecting children and young people from harm and supporting people of every age. The work they do can be difficult and very demanding, requiring careful professional judgements that can make all the difference to those they serve.”*

*(Extract from ‘Building a safe and confident future’, the final report of the Social Work Task Force, November 2009)*

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1. This is the final report of the review of child protection arrangements commissioned by the County Council in December 2008, following the publication of the urgent Joint Area Review in Haringey carried out in response to the death in 2007 of Baby Peter.
2. The quote with which this Executive Summary begins is not intended to diminish the role of other professionals and agencies in protecting vulnerable children from harm, abuse or neglect. Together with other key frontline professionals, particularly Police Officers and Health Visitors, Social Workers face the difficult daily task of protecting the most vulnerable in our society.
3. That said, the skills, expertise and professional training of Social Workers, together with their statutory obligations, give them a unique and pivotal role in child protection work. As the initial report in February 2009 concluded, *“....whilst systems and procedures play important roles, the protection of vulnerable children fundamentally relies on sound professional practice by social workers and others, armed with skills in assessing risk, skills in working directly with families and in a spirit of ‘respectful scepticism’, and skills (and confidence in those skills) to make inherently difficult judgements and who are supported to exercise those skills by sound professional supervision, training and management...”*

4. As this report will show – and the previous reports by the Review Team have shown - much has already been done in Kent to assess the robustness and integrity of child protection arrangements in Kent and where necessary, steps have already been taken by KCC and by the Kent Children Safeguarding Board to further strengthen those arrangements.
5. Although the death of Baby Peter was very tragic and its aftermath has perhaps seen a further erosion of public confidence, it is important to keep recent events in perspective and in their historical context. The rate of child deaths in the UK was more than halved between 1970 and 1995. Using Home Office statistics, the NSPCC states that “On average, 67 children in England and Wales are killed at the hands of another person every year” – whilst approximately 38,000 children are on child protection plans at any one time. As recent research indicates, the incidence of child homicide in the UK is the lowest in the English-speaking world and compares favourably with the majority of European countries. It is noteworthy, however, that in contrast to these data, public perceptions of risk and safety are also influenced by other factors such as, for example, the purpose and requirements of the Criminal Records Bureau. Despite its undoubted value, the existence of the CRB has been said by some commentators to have the unintended consequences of creating a ‘background’ climate of mistrust and undermining the personal, as opposed to state, responsibility for the protection of vulnerable people.
6. Notwithstanding the recent publicity surrounding the death in November 2008 of a very young baby in Kent and her father’s recent conviction for manslaughter, the position for children in Kent is one of much greater safety than the national picture. The national rate for violent child deaths in England and Wales in 2006 is reported in Professor Colin Pritchard’s most recent research as 17 per million. Using comparable data for violent child deaths in Kent between 1997 and 2009, the incidence is 6 per million – or two-thirds less than the national incidence.
7. That said, complacency is the enemy of the maintenance of high practice standards. Constant vigilance and the pursuit of improvement are essential – reliance on good practice standards, policies and procedures can only give solid assurance if compliance with them is diligently monitored. As this report indicates, referrals have continued to rise over the last year and recruitment and retention of Social Workers in Children’s Social Services has continued to be an ongoing challenge in Kent, just as elsewhere.
8. In this final stage of the review, the Review Team have sought to relate the assessment of local arrangements to the national developments that have flowed from Lord Laming’s Progress Report of March 2009 and the subsequent key policy and regulatory developments by which the Government has responded to his recommendations. With this in mind, this report commends some proposals for a strategy for defending and developing child protection services for the County Council and the Children, Families & Education Directorate to consider.

9. On 18 March 2010, a number of key national reports on safeguarding vulnerable children were published by the Government. These include:

- “The Government’s Response to Lord Laming – One Year On”, setting out the government’s view of progress;
- Sir Roger Singleton’s first annual report to Parliament in his capacity as the Government’s Chief Adviser on the Safety of Children, setting out his view of progress on implementation of Lord Laming’s 58 recommendations;
- the revised statutory guidance, “*Working Together to Safeguard Children*”.

10. As these important and highly relevant reports were published only the day before this report, it has not been possible to consider their findings and reflect them in this report. Accordingly, it is suggested that an analysis of the main messages and implications of these reports is incorporated into the detailed response and action plan that is recommended below..

11. In summary, the review recommends:

- The main elements of the proposed strategy should be the basis for further detailed review and refinement by the **Managing Director of Children, Families & Education Directorate, the Director of Specialist Children’s Services** and their staff, including an analysis of the national reports published on 18 March 2010.
- The **Kent Safeguarding Children Board** should give positive consideration to undertaking a multi-agency peer review of a sample of current child protection cases to assure itself about practice standards across agencies. (See Paragraph 20)
- The **Kent Safeguarding Children Board** should identify and report on steps taken to improve the culture of openness and exchange between member agencies and its actions to establish greater accountability to the KSCB for child protection standards within member agencies. (See Paragraph 21)
- The independent Chair of the **Kent Safeguarding Children Board** should present an annual report to the Kent County Council. It is also recommended that this report is also taken to all other relevant public bodies in Kent at Board level. (See Paragraph 22)
- **Kent Children’s Social Services** should make regular use of the Social Work Task Force’s organisational self-appraisal tool to ensure it is achieving high standards as a social work employer. (See Paragraph 43)

- The **Kent Safeguarding Children Board** should, as a standard practice deliver multi-agency seminars and targeted training following every serious case review to ensure that the lessons from the reviews are quickly and efficiently promulgated. (See Paragraph 52)
- **Kent Children's Social Services** should maintain a continuous review programme to ensure the adequacy of administrative support services and systems for social workers with a view to reducing professional social work time spent on administration and increasing the direct client contact time. (See Paragraph 57)
- **Kent Children's Social Services** should establish partnerships with other local authorities to share approaches aimed at minimising the administration workload of social workers and to seek shared solutions through the joint development of efficient, casework-oriented, and user-friendly information technology programmes. (See Paragraph 57)
- **Kent Children's Social Services** and the **Kent Safeguarding Children Board** should ensure a good standard of referral information through training programmes and quality assurance audits with partner agencies. (See Paragraph 58)
- Urgent action should be taken by **Kent Children's Social Services** to reduce the rate of abandoned calls to the Kent Contact and Assessment Service, based at Kroner House. (See Paragraph 60)
- **Kent Children's Social Services** should give high priority to the current review of their staff supervision policy with the objective of making professional social work supervision a guaranteed and protected element of the service with protected time for practitioners and supervisors. (See Paragraph 62)
- The **Kent Safeguarding Children Board** should develop in partnership with appropriate academic and other training institutions electronic and interactive training packages that can be used for workplace training and team development of skills necessary for child protection work across and specific to agencies. (See Paragraph 63)
- **Kent Children's Social Services** should establish a trainee scheme for suitable candidates for professional social work training and provide financial assistance through training professional training in return for a contractual commitment to remain in employment with the county for a minimum of two years after qualifying. (See Paragraph 66)

- **Kent Children's Social Services** should seek to establish a number of bursaries or sponsored places on suitable social work training courses. (See Paragraph 67)
- **Kent Children's Social Services** should establish close partnerships with suitable centres of academic excellence to develop training and research programmes that will meet the demands of child protection social work. (See Paragraph 70)
- The **Kent Safeguarding Children Board** and **Kent Children's Social Services** should develop training initiatives that will ensure that all professionals in the course of their qualifying training have joint training modules to increase the shared professional understanding of child protection work and to establish a core of inter-professional skills and knowledge. (See Paragraph 70)
- **Kent Safeguarding Children Board** and **Kent Children's Social Services** should seek to establish a multi-agency specialised training unit, ideally in partnership with all agencies, within the county aimed at developing the necessary skills for working with difficult uncooperative families. (See Paragraph 71)
- **Kent Children's Social Services** should establish robust mechanisms for providing advice and alerts to senior managers and to elected Members and which will also provide reassurance to social workers that their professional values and ethics are being promoted and safeguarded. (See Paragraphs 72 and 73).
- **The Leader and Chief Executive/Group Managing Director** should arrange with the Director of Children Services, the Director of Specialist Children's Services and the independent chair of the Kent Children's Safeguarding Board an annual programme of reporting to Cabinet and full Council to provide an open and systematic approach to quality assurance. This programme should be managed through the Managing Director for Children, Families & Education and the Director of Specialist Children Services and coordinated by Corporate Policy, supported with advice from a reference group comprising frontline practitioners. (See paragraphs 72 and 73)



# SAFEGUARDING CHILDREN IN KENT: DEFENDING AND DEVELOPING THE SERVICE

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This report concludes the review of Kent County Council's child protection services undertaken at the request of elected Members in December 2008. It provides an overview of the process and its findings and, within the context of national developments, recommends elements for a strategy for maintaining an effective standard for safeguarding children who may be at risk of abuse or neglect.

Previous reports have been presented to the Children's Champions Board on:

- 12 February 2009
  - 20 May 2009 (verbal report)
  - 21 July 2009
  - 10 March 2010 (verbal report)
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*"... the job social workers do is critical to the nation. They play an essential role in protecting children and young people from harm and supporting people of every age. The work they do can be difficult and very demanding, requiring careful professional judgements that can make all the difference to those they serve."*<sup>1</sup>

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## Introduction

1. In response to the national concern about standards of child protection raised by the reviews and inspections in the London Borough of Haringey following the death of baby Peter Connolly, Kent County Council resolved that an independent review of Kent Children's Social Services safeguarding practice should be undertaken by the Chief Executive<sup>2</sup>. In view of the important multi-agency responsibilities for protecting children, the review was extended to include three distinct components:

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<sup>1</sup> Introduction to *Building a safe and confident future*, the final report of the Social Work Task Force: November 2009, Department of Children, Schools and Families.

<sup>2</sup> Kent County Council meeting of 11.12.08

- Assessing if children are properly protected by Kent Children's Social Services
  - Assessing if other relevant agencies in Kent are discharging their child protection responsibilities effectively
  - Assessing the impact of national developments on the current and future protection of children in Kent
2. **Phase I** of the review concentrated on Kent Children's Social Services and reports presented to the Children's Champions Board during 2009<sup>3</sup> indicated that the child protection processes of Children's Social Services are operating effectively and that responses to new and existing referrals where a child may be at risk of abuse or neglect are timely and appropriate. In accordance with the request by the Secretary of State for Children Schools and Families to all local authorities in November 2008, the safeguarding review paid particular attention to the shortcomings identified in Haringey by formal inspections following the death of baby Peter Connolly. Although the review found some of the Haringey features could be identified as stress factors in Kent Children's Social Services (e.g. staff shortages, time-consuming requirements of the national Integrated Children's System of computerised recording and rising rates of child protection referrals), they did not represent an immediate and high level of risk in managing existing child protection cases and the response to new child protection referrals was timely and professional. In common with most local authorities, Kent is managing its service under considerable pressure and the commitment and dedication of practitioners, managers, and administrative staff is indispensable to the maintenance of an effective standard of service in the face of increasing referral rates. Due to the variety of pressures on social services departments, it is important that there is constant vigilance and that prompt management action is taken to resolve pressures that may impinge on the organisation's ability to respond in an appropriate and timely manner is monitored safe operation of the child protection process.
3. **Phase II** of the review concentrated on the inter-agency aspects of child protection and involved the Kent Safeguarding Children Board (KSCB) as "the key statutory mechanism for agreeing *how the relevant organisations in each local area will co-operate* to safeguard and promote the welfare of children in their locality, and for *ensuring the effectiveness of what they do*."<sup>4</sup>

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<sup>3</sup> See reports and minutes presented to the Children's Champions Board meetings of 12.02.09, 20.05.09, and 21.07.09.

<sup>4</sup> Children Act 2004 and statutory guidance contained in *Working Together to Safeguard Children* (2006), Paragraph 3.2 (the italics have been added for emphasis).

For a child protection system to be effective, all agencies<sup>5</sup> with responsibilities for the safe care of children must have robust and efficient child protection processes and there must be good inter-agency communication and co-operation in identifying and assessing children who may be at risk of significant harm and in working together to implement child protection plans.

4. This phase of the Safeguarding Review has involved working closely with the KSCB's Performance Sub Group in a programme of appraising its member agencies' own quality assurance reviews and in a further review of their inter-agency responsibilities.
5. The commitment of the KSCB has been very positive and the work of its Performance Sub Group has been useful in forming a view regarding the fitness of collective agency child protection processes. However, the complexity of member agencies' internal review processes and the understandable need to balance the nurturing of good relationships, with discretion, have meant that the review team has been unable to form a really detailed view of how the individual agencies operate.
6. Although member agencies of the KSCB will have complied with the Secretary of State's request that all agencies should undertake their own reviews of practice pending the completion of the national review by Lord Laming, only Kent Children's Social Services, through the process of this review, have decided to make their findings public. It is the review team's opinion that this may have been a missed opportunity for all agencies to increase transparency and the public understanding of the complexities and challenges that face all agencies engaged in child protection. The review team would strongly encourage partners to share the results of these internal reviews with their partner agencies on the KSCB. Although it is assumed that the management boards of individual agencies are satisfied the process has been completed to a satisfactory standard and that action has been taken where improvements are indicated, a greater sense of co-ordination could certainly have been achieved if a more open approach had been adopted. The function of the KSCB in monitoring and ensuring the effectiveness of child protection within and between agencies is constrained unless member agencies adopt a more open attitude.
7. The KSCB is actively considering measures aimed at improving this situation by seeking the agreement that all member agencies will formally notify the Performance Sub Group of any child protection audits they are conducting

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<sup>5</sup> Agencies with specified responsibilities for child protection and the duty to co-operate are defined by Section 11 of the Children Act 2004.

together with details of the methodology, results when completed, and where deficiencies are identified, further reports regarding remedial action. Agreement to this development will considerably enhance the effectiveness of the KSCB and will provide an additional and transparent element of accountability for its member agencies.

8. Despite the lack of detailed insights that can be given regarding other agencies' internal review processes, the KSCB has clearly started to make good progress in assessing three critical questions relating to child protection work:
  1. What works well in terms of inter-agency partnership practice in safeguarding children?
  2. What gets in the way in terms of multi-agency working partnership practice in safeguarding children?
  3. Are there any actions you would like the Board to take forward?

Response to these questions was varied and is the subject of continued appraisal. However, the following generalised opinions are evident and will form the basis of further action by the KSCB:

**What is working well in inter-agency child protection work?**

9. In response to the first question, much is working well already. Many respondents set great store on direct contact between referrers and those social workers – and police officers – involved in responding to allegations of child abuse or neglect. This is seen as a key means of improving mutual understanding. Such direct contact may be in connection with individual referrals or via MARAC meetings or other local forums for multi-agency case-discussion and learning. This has been reflected in the emphasis the Performance Monitoring Sub Group has placed on encouraging the development of local face-to-face mutual quality-assurance activity. The importance of front-line professionals from different agencies developing mutual awareness of and confidence in others' work is a repeated theme.

**What gets in the way of good inter-agency child protection work?**

10. The response to the second question indicated a general concern regarding a lack of awareness of respective roles and responsibilities which undermines good effective working between agencies. This is reported as a concern by some colleagues from, for instance, district councils, for whom dealing with child protection is a less frequent and non-core activity.
11. A further impediment to good inter-agency working was identified as the differential interpretation of thresholds for intervention, especially around the circumstances that deem a referral to be one of 'child protection' or a 'child in need'. Put at its simplest (and that has inherent difficulties), some agencies

who refer cases to CSS for assessment and investigation regard their referral as one of child protection but, from their viewpoint, CSS appears to underestimate the seriousness of their concerns by treating it as a 'child in need' referral. In the absence of hard data, it is not possible to put a figure on the frequency of differential interpretation – or professional difference of opinion, as some might term it – but it seems a sufficiently frequent occurrence for several respondents to remark upon this as an impediment to more effective joint working. This difficulty has also been identified as a factor in the review of serious case reviews undertaken by Edinburgh University (see Paragraphs 15 - 18).

12. This situation may be exacerbated by incidents of actual or perceived lack of feedback from CSS (as cited by some referring agencies), the poor quality of some referrals (as cited by comments from, primarily, CSS colleagues), and the apparent reluctance of all parties to utilise local escalation protocols to resolve differences of opinion. All of these factors can contribute to an area of potential and unresolved risk.
  13. For important colleagues who are nevertheless working in 'non-core' agencies, the less clear relationship between safeguarding and protection is an issue which leaves some uncertain as to where they should be focussing their resources and activities. Also, some still feel unengaged in and confused about other "Every Child Matters" policy initiatives such as the Common Assessment Framework (CFA), Contact Point and Single Point of Access (SPA) or bemused by the sometimes off-putting associated plethora of jargon, acronyms, and mnemonics.
  14. Issues about specifying, assuring and accessing training; the robustness with which policy and practice guidance is disseminated from the Board across all partner agencies in a timely and comprehensive manner and comments about confidentiality as inhibiting the exchange of referral information round off the kinds of concerns that agencies identify as inhibiting more effective work.
- Serious case reviews**
15. Another dimension by which the effectiveness of inter-agency work can be judged is the findings of Serious Case Reviews (SCRs). The KSCB is to be applauded for the research it commissioned in June 2009 from the University of Edinburgh and the NSPCC Centre for UK-wide Learning in Child Protection to analyse the 24 Serious Case Reviews that took place in Kent between 2000 and 2009. Members must remember that the 24 SCRs studied represent a very small and atypical sample of outcomes for the many thousands of vulnerable children and young people on child protection plans who have been protected and supported by social workers, the police, health professionals and other agencies in Kent over that period.
  16. The findings of the overview of these reviews reflect many of the themes identified in national surveys of serious case reviews. Of particular interest is the reviewers' opinion that many of the cases were highly individualised and although some involving long-term neglect could be considered as fairly

typical of this type of case, “others contained unique and complex factors which are far less likely to be familiar to professionals”. Further, they found “There was also a distinct absence of risk factors in some cases.”

17. From this small, but important, sample of serious child protection cases, the review drew attention to the prevalence of the following factors:
- Mental health problems in parents
  - Housing problems
  - Volatile family relationships
  - Professional differences in interpretation of procedures and thresholds
  - Difficulties in working with parents (problems of maintaining focus on the needs of the child; over-optimism regarding parental capabilities or sustained improvements; accepting parental explanations without question; dealing with intimidating, hostile and manipulative parents)
  - Ensuring an adequate tracking system for adults who may pose a risk to future children (e.g. fathers who have abused children, then leave the family and establish new relationships and produce new children)
18. With the exception of the need to establish reliable tracking and alerting systems for adults who pose risks to future children, awareness of many of the above factors can be raised through focused multi-disciplinary training programmes.

### **Conclusion to Phase II**

19. Despite the factors identified, the review team member co-opted to the Performance Monitoring Sub Group found there was no evidence to suggest significant risk or clearly dysfunctional working in the inter-agency child protection processes. Those items that do need attention are not matters which are, of themselves, unique to 2009 but nevertheless have been highlighted by the reactions to the Baby Peter case. What these commentaries indicate is, perhaps, that the greatest enemy of consistently good safeguarding practice is complacency. Like painting the Forth Bridge, the Board’s work can never be completed.
20. Nevertheless, the advice of the review team is that the Performance Monitoring Sub Group consider again the quality assurance benefits of a multi-agency peer-review of a sample of current cases of children who are subject to child protection plans to assure themselves about practice standards across agencies, in addition to the actions it has already taken and continues to take to implement the learning from the 2009 Section 11 review.
21. Furthermore, the KSCB should continue to develop a culture of openness and exchange between its member agencies and it should be active in encouraging greater sharing. If necessary, this should include both self- and mutual criticism with regard to joint child protection work.
22. Transparency and public trust in the functioning of good child protection services in Kent will be considerably enhanced by comprehensive annual

reports by the Safeguarding Board to the County Council and other public bodies

23. **Phase III** of the review is intended to place the findings of Phase I and II in the context of national factors and developments influencing the child protection functions of local authorities and other agencies. In formulating strategies to preserve the current standard of service in Kent and to develop and improve it where necessary, it is essential that account is taken of circumstances and influences, some of which are beyond the direct control of the local authority, that will influence its ability to provide an effective child protection service and the manner in which it is delivered. These are discussed in the following paragraphs.

### **National factors influencing local authority child protection services**

24. In order to defend and develop the current standard of service, it is necessary to take account of the wider context within which the local authority discharges its statutory child protection duties. This involves an understanding of the historical context, the need for proportionate responses, current developments in the social work profession, and current and anticipated financial constraints. The implications of each will need to be taken into account in formulating a strategy for maintaining and improving child protection services.

#### **The historical context**

25. Current child protection processes have been shaped significantly by the experience of previous child abuse tragedies. Most current child protection processes (e.g. the establishment of measures to co-ordinate the work of different agencies, the child protection conference, and identifying individual children as being specifically in need of protection) have their origins in a sequence of formal inquiries commencing with the death of Maria Colwell in 1974.<sup>6</sup> In recent years, the inquiry into the death of Victoria Climbié<sup>7</sup> chaired by Lord Laming and his recent review of national child protection services<sup>8</sup> have had extensive implications for children's services in general, as well as being the precursors of this review. The Victoria Climbié Inquiry concluded there was a gross failure of the system of public agencies responsible for protecting vulnerable children from deliberate harm and made 108 recommendations for amending and improving child protection services. The subsequent progress report made a further 58 recommendations for improving child protection services. These and the previous

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<sup>6</sup> Report of the Committee of Inquiry into the care and supervision provided in relation to Maria Colwell. HMSO, 1974.

<sup>7</sup> The Victoria Climbié Inquiry report by Lord Laming. HMSO, 2003.

<sup>8</sup> The Protection of Children in England: A Progress Report by Lord Laming. HMSO, 2009.

recommendations arising from over 70 major inquiries held since Maria Colwell have led to the construction of a child protection process whose purpose is not only to ensure an adequate response where children are at risk of abuse but which also aims to avoid the systemic failures which led to previous tragedies. In this sense recommendations from inquiries may be considered reactive and corrective to previous failures.

26. Concurrent with the developments arising from child death inquiries, research and initiatives aimed at improving the service to children in the public care system and in wider society have also influenced national policy and legislation. For example, the publication of *Child Protection: Messages from Research* in 1995<sup>9</sup> drew attention to the relatively poor outcomes for children taken into local authority care and proposed that family support should be the preferred option to protect the majority of children from abuse and neglect. More recently, government policy initiatives have significantly affected the nature of children's services. The *Every Child Matters: Change for Children* programme and the associated Children Act 2004 have expanded all agencies' responsibilities. All children's services are being more closely integrated in order to improve the outcomes for all children and there is a general requirement that not only should children be protected from deliberate harm (i.e. part of the outcome of "staying safe") but *all* children should also achieve the four additional outcomes of being healthy, enjoying and achieving, making a positive contribution, and achieving economic well-being. Although many initiatives have included elements of child protection, their scope has often had the global objective of aiming to improve outcomes for all children *in addition* to those considered to be at risk of significant harm. This broadening of objectives, unless properly resourced, can have the unintended consequence of diminishing the resources and focus necessary for the effective protection of children.
27. The developments arising from research and these comprehensive child welfare policies are to be welcomed and services aimed at preventing family breakdown and the stresses that may lead to abuse or neglect are preferable to intervening after abuse has occurred. However, the commendable emphasis on improving outcomes for all children and narrowing the gap between disadvantaged and normally achieving children has placed considerable demands on children's social services departments and their partner agencies: demands that are *additional* to the statutory requirement to protect children at risk of significant harm.<sup>10</sup>
28. Both strands of policy and service development (i.e. the "corrective" arising from identified shortcomings and the "prospective" arising from research and

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<sup>9</sup> Compiled by the Dartington Social Research Unit. HMSO 1995.

<sup>10</sup> Children Act 1989, Section 47.



policy aspirations) are necessary for the improvement of child protection practice and for improving outcomes for children whose life chances are affected by abuse or other disadvantage. However, expanding child welfare aspirations and the introduction of new procedures and policies carry the risk of monopolising organisational and professional attention to an understandable but risky degree.

29. Such a preoccupation can diffuse the focus on existing child protection fundamentals. For example, the publication of *Messages from Research* in 1995 (see Paragraph 26) prompted an appropriate examination of practice to ensure that children should remain in the care of their families of origin wherever possible and emphasised the importance of family support. Whilst inappropriate removal of a child is damaging, the simplistic implementation of policies to keep children at home can have the unintended consequence of engendering an organisational and professional resistance to removal, making it an action of last resort only justified by incontrovertible proof of serious harm. In attempting to conform to this new emphasis in practice development, it is possible that children were left in risky home environments when there was little potential for improvement. There is evidence that the numbers of children registered as being at risk of abuse declined dramatically following the publication of *Messages from Research* which in turn, influenced the guidance issued in the first edition of *Working Together to Safeguard Children* in 1999. In 1991, 49,000 children were recorded on English child protection registers. By 2000, the new guidance and effect of the family support emphasis of the Children Act 1989 had resulted in the total dropping to 35,000, a reduction of nearly 30%.<sup>11</sup> It is unlikely that the actual incidence of child abuse and neglect had achieved a similar reduction in the same period.
30. Although it could be argued that too many children had been placed on child protection registers before the change of emphasis engendered by the above publications, the marked change in registrations can also be seen as evidence of a pendulum effect where responses to high profile cases or research results in an unintended over-correction. This view is supported by the fact that the number of children, nationally, who are the subjects of child protection plans<sup>12</sup> subsequently increased from 25,700 in 2002 to 37,900 in 2009.<sup>13</sup> This increase of 48% suggests a compensatory adjustment to a previously over-enthusiastic application of the guidance of 1999. A similar example is suggested by the changing pattern of the primary category of

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<sup>11</sup> Office for National Statistics: "Children on child protection registers: by gender and category of abuse, 2000". Social Trends 32.

<sup>12</sup> Child protection registers were discontinued in 2008 but a child with a formal child protection plan is the equivalent to a child who would previously been placed on a child protection register.

<sup>13</sup> "Referrals, assessment and children and young people who are the subject of a child protection plan, England – Year ending 31 March 2009, DCSF.

registration which has shifted over the years from the majority of cases being registered for physical abuse, to a subsequent majority of registrations for sexual abuse, to the current predominance of registrations for neglect. These changes appear to reflect public and media preoccupations which may often influence policy initiatives. Again, it is unlikely that the *actual* incidence of each of the categories of abuse has changed in proportion to each other; the fluctuations are more likely to be the result of professional over-reaction as, for example, in the high profile given to the so-called “satanic abuse” of children in the 1980’s.<sup>14</sup>

31. Changes in the reactions to child protection concerns illustrate the inherent problems of achieving a proportionate response that achieves the objective of protecting children from abuse and neglect but which also avoids unwarranted interventions. Although concerns must be investigated and assessed, a disproportionate response is damaging in its effect on the children and families concerned and wastes resources. Despite advances in knowledge and skills in this difficult area of social work practice, a significant element of child protection work is dependent on professional judgements and a balance of risk factors. These judgements are inevitably influenced by the media presentation of the very small percentage of child protection failures which in turn affect the thresholds which trigger referrals to social services. Evidence of this is apparent in the tensions regarding thresholds and interpretation of “risk” and “need” revealed by the recent work of the Kent Safeguarding Children Board (see Paragraphs 11 and 17).
  
32. In order to ensure that children are properly protected and that interventions are appropriate and proportionate, it is important that new policies and their objectives are thoroughly understood throughout all levels of organisations. Assessment and interventions must be based on comprehensive and professionally objective criteria rather than any unintended bias that may be projected onto new initiatives. It is also important that the focus and energy absorbed by new initiatives does not diminish the sustained and careful application of established policies and practice necessary for safe and effective child protection. The achievement of this level of understanding and balance is largely dependent on organisations having the capacity to understand thoroughly the intention behind new initiatives and procedures and not merely the mechanical processes involved in their implementation. Managers may require expert advice (from within or external to their agency) to fully appraise the implications of new national initiatives and practitioners will require the time to complete the necessary training. In social work, professional supervision is an essential safeguard to ensure that new initiatives are applied appropriately in individual cases.

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<sup>14</sup> “Extent and Nature of Organised and Ritual Abuse”, J.S. La Fontaine. HMSO, 1994.

33. To avoid responses being skewed by an over-emphasis on the latest research or inquiry findings, the question is not only to assess how we are doing in relation to the latest tragedy (as in the current emphasis on ensuring we do not have similar shortcomings to those identified in Haringey) but whether we have a robust system capable of protecting all children where there is concern about abuse or neglect. A searchlight that illuminates only selected areas of the whole terrain of the child protection process can leave other areas dangerously in the dark! The strategy which is recommended for defending and developing child protection services in Kent includes measures that are intended to maintain a balanced response to the demands of new developments and initiatives.

**The wider concept of “safeguarding”**

34. Reference has been made to the *Every Child Matters* initiatives aimed at improving a broad range of outcomes for children. These included the concepts of staying safe and “safeguarding” and the replacement of Local Child Protection Committees by Local Safeguarding Children Boards.<sup>15</sup> The concept of safeguarding includes protecting children from physical abuse, sexual abuse, emotional abuse, and physical neglect. However, local authorities and partner agencies are also required under the Staying Safe Action Plan<sup>16</sup> and its associated Public Service Agreement<sup>17</sup> to take action to safeguard children from harm arising from bullying, Internet use, crime, road traffic accidents, and a number of other sources of potential risk.
35. The aim of improving the safety of all children cannot be criticised and there is evidence that progress has been made in meeting the goals established in this broadening of objectives. The Government’s “Staying Safe Action Plan” aimed to “help all children and young people to stay safe” and responses to the consultation process associated with this strategy indicated “The majority of respondents of all ages felt that children and young people in general are currently safe, secure, and well looked after, although there was still concern about some specific issues.”<sup>18</sup>
36. This broadening of concept from child protection to safeguarding has placed increased demands on social service departments and partner agencies. It is creditable that advances have been made in the general safeguarding of children but it is important that attention and organisational energy is not

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<sup>15</sup> Children Act 2004, Section 13 and Working Together to Safeguard Children (2006 Edition), Ch 3.

<sup>16</sup> Published by the Department of Children, Education and Families in 2007.

<sup>17</sup> PSA No 13, July 2009.

<sup>18</sup> Responses from the *Staying Safe* consultation, 2007.

spread too thinly over a broad range of objectives. Current policy directives suggest the need for three levels of safeguarding<sup>19</sup>:

1. Universal
2. Targeted
3. Responsive

For the effective protection of children who are at risk of significant harm from abuse or neglect, it is essential that social services and other organisations directly responsible for identifying and protecting this group should place a high priority on the targeted and responsive elements of safeguarding, i.e. child protection.

### **Themes from serious case reviews and inquiries**

37. Overview reports collating common themes in child protection failures have been published by the Department of Health and subsequently, the Department of Children, Schools and Families.<sup>20</sup> In the national inquiries and in serious case reviews, there is a marked correspondence of themes that have contributed to failures to provide adequate protection. Although caution should be exercised in generalising these findings (only half of the children subject of 189 serious case reviews conducted between 2005 and 2007 were known to their local social services department) and not all of them featured in the recent survey of Kent serious case reviews (see Paragraphs 15 -18), it is depressing that these themes do not appear to alter over the years. Broadly, they are:

- Factors indicating risk of abuse or neglect were evident in most cases but not necessarily shared amongst agencies to give a more compelling case for intervention
- Associated with the above: poor inter-agency communication
- Failure to comply with agreed child protection procedures
- Problems presented by non-compliant families or those who disguise their non-compliance and the need for “respectful uncertainty” on the part of professionals

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<sup>19</sup> Staying Safe Action Plan

<sup>20</sup> The most recent being *Understanding Serious Case Reviews and their Impact – A Biennial Analysis of Serious Case Reviews 2005-07*, DCSF, June 2009.

- Fixed thinking on the part of professionals (reluctance to change assessments in the light of new information)
  - Poor record keeping
38. If these factors are to be guarded against, agencies must have the processes to keep practice under constant review and to ensure practitioners and managers have the time for good reflective supervision and training. Agencies need to focus on what Lord Laming describes as “doing the relatively straightforward things well”.<sup>21</sup>

### **Proportionality**

39. Intervening in the lives of families where children are at risk of abuse demands a high level of professional skill and experience. It places emotional demands on practitioners who, on occasion, may also face physical risk. The work patterns are unpredictable and require flexibility from individual workers and from the agency. It involves a high level of professional responsibility to ensure that interventions are appropriate; that children are not removed unnecessarily from families; that their lives are not disrupted and at the same time, are not placed at risk. All this has to be achieved in the face of increasing referrals. In the year ending 31 March 2009, local authorities in England recorded a total of 547,000 referrals for children who were in need (including those possibly at risk of abuse or neglect). Of these, 349,000 (64% of the original referrals) received an initial assessment and of those that had an initial assessment, 120,600 went on to be subject to a comprehensive or “core” assessment. This resulted in 37,900 children and young people being made the subject of a child protection plan (i.e. only 7% of the original 547,000 referrals).<sup>22</sup> Many of the children who were not made subject to child protection plans had other needs identified which would have required the allocation of a social worker and often required additional services from other agencies. The high risk cases have to be managed as part of the total and increasing demands on social work departments. It is to their credit that most children and families receive an appropriate service and that most children who are known to social services as being at risk of abuse are protected.
40. Although only one child death is a tragedy, it is important to place child abuse fatalities in the context of the successes of the current system. The rate of child injury deaths in the UK more than halved over the 25 years between 1970 and 1995.<sup>23</sup> Statutory reviews of *all* deaths of children under

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<sup>21</sup> The Victoria Climbié Inquiry report by Lord Laming. HMSO, 2003

<sup>22</sup> DCSF: *Referrals, assessment and children and young people who are the subject of a child protection plan, England – Year ending 31 March 2009*.

<sup>23</sup> Research review by ADSS in briefing notes on issues relating to the Victoria Climbié Inquiry.

the age of 18 conducted by Local Safeguarding Children Boards in 2009 indicate that only 5% were considered to be preventable.<sup>24</sup> Of the 110 deaths that were judged to be “preventable” in 2008-09, only a small number were due to abuse or neglect and of these, not all would have been known to local social services departments. Based on Home Office statistics, the NSPCC proposes that “On average, 67 children in England and Wales are killed at the hands of another person every year”.<sup>25</sup> Due to the complexity of gathering and recording relevant information, these assertions may only be considered as estimates which are probably conservative. However, 67 fatalities compared to 37,900 children being protected would suggest that, for most of the time, our child protection system is operating effectively. The incidence of child homicide in the United Kingdom is low compared with other countries. The USA recorded 1,800 juveniles as the victims of homicide in 1999<sup>26</sup> and more recently Australia indicated that school-age children were twice as likely to be killed and pre-school children 1.5 times as often as in Britain.<sup>27</sup> Attempts at improving the child protection system in England should guard against any potential diminishing of the current level of success.

#### **Current developments in the social work profession**

41. There are significant developments affecting the future of the social work profession which will have major implications for local authorities and their child protection responsibilities. These arise from the recommendations of the recently published final report of the Social Work Task Force<sup>28</sup> which have been accepted in total by government and which are intended to be implemented over the coming years. (Details of the implementation timetable and strategy will be published by the Social Work Reform Board early in 2010.) Of the 15 core recommendations, the following will have particular implications for local authorities in their roles as employers of social workers and providers of child protection services:

- Recommendation 6 – Establishing a national standard for the support social workers should expect from their employers in order to do their jobs effectively
- Recommendation 7 – Establishing clear requirements for employers to ensure regular,

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<sup>24</sup> *Preventable Child Deaths in England: Year Ending 31 March 2009*, statistical release by DCSF

<sup>25</sup> Child homicides – Key child protection statistics

<sup>26</sup> David Finkelhor & Richard Ormrod, Office of Juvenile Justice and Delinquency Prevention Bulletin, October 2001.

<sup>27</sup> Medical Journal of Australia as reported in *The Australian*, 5 January 2009.

<sup>28</sup> *Building a safe, confident future* – The final report of the Social Work Task Force: November 2009, DCSF

supportive and reflective casework supervision for social workers

- Recommendation 8 – Providing training and support for frontline social-work managers
- Recommendation 9 – Providing continuing professional development training for social workers
- Recommendation 10 – Providing a national career structure for social workers

42. It is relevant to note that the recommendations apply to *all* fields of social work, i.e. adult care and the whole range of child care responsibilities, of which child protection is but one aspect. The resource implications for local authorities are therefore considerable and extend beyond the boundaries of child protection social work. It is also important to note that due to their very recent acceptance, the resource requirements of these recommendations and their associated cost implications have yet to be estimated at national and local level. It is possible that the newly constituted Social Work Reform Board will address this aspect of implementing the reform programme. However, there is little doubt there will be substantial costs associated with the reforms and many of these will have implications for local authorities. In the current economic climate, where major constraints on public finances are inevitable, local authorities will face difficult decisions regarding the allocation of resources between and within their whole range of services. These decisions will need to be informed by sound professional and managerial information and advice backed by the political will to make what may be unpopular decisions to prioritise spending in order to defend and develop effective child protection services that do not hover at the margins of safety.

43. Whilst awaiting the deliberations of the Social Work Reform Board, local authorities are encouraged to review the operation of their own social services departments to help them move towards the aspirations of the Task Force recommendations. A framework for organisational self-appraisal is included in the Task Force report<sup>29</sup> and is commended to all organisations providing social work services. (A copy is appended to this report.) Whilst the regular management review and quality assurance programme currently operated by Kent Children's Social Services includes many of the review items in the Task Force framework and Phase I of this safeguarding review also addressed some of the items, the regular use of this tool will provide a

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<sup>29</sup> The final report of the Social Work Task Force: November 2009, Annex A: Organisations and workloads.

valuable indicator of how well the department is functioning as a facilitator and supporter of good social work practice.

44. In addition to the implications of the Social Work Task Force recommendations, the government acceptance of all of the recommendations made in Lord Laming's progress report of March 2009 also has profound implications for social work and the authorities responsible for its delivery. There is little doubt that implementing these recommendations will have both practice and cost implications. Recent research completed on behalf of the Local Government Association by Loughborough University<sup>30</sup> outlines the potential costs involved if *all* referrals to children's social services by another professional receive an initial assessment. The research also draws attention to the steep rise in referral rates to social services and the national shortage of qualified social workers necessary to meet this demand.

### **KENT'S ACHIEVEMENTS AND CHALLENGES**

45. Kent has an established record of responding quickly to national developments in social services. Examples of past achievements in the field of children's services and child protection serve to illustrate this:
- Establishment of sound finances for the Kent Child Protection Committee (now the Kent Safeguarding Children Board) long before the majority of similar committees in other local authorities
  - The development of joint training initiatives for social workers and police officers
  - Establishing close training and research links with centres of academic excellence
  - Establishing a career structure to enable experienced social workers to remain in practice with enhanced remuneration
46. These and other innovations have often been introduced at times of change and challenge and have contributed to the consistently favourable inspection results achieved by the county. The same level of application and adaptability will be necessary if child protection services are to be maintained at a safe standard in times of increasing demand, professional change, and financial constraint. Although the implications of the current changes in the

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<sup>30</sup> "Calculating the Cost and Capacity Implications for Local Authorities Implementing the Laming (2009) Recommendations" – Lisa Holmes, Emily Munro, Jean Soper: Centre for Child & Family Research, Department of Social Science, Loughborough University. March 2010.



structure of the social work profession have yet to be calculated in detail and the medium and long-term impact of financial constraints on local authorities may be unclear for some time, it is certain that all local authorities will have to confront the dilemma of meeting increasing demand with restricted or diminishing resources. Previous reference has been made to the national situation regarding child protection. It is relevant to place Kent's situation in comparison with this.

47. **Incidence rates** – Compared with the national rate for violent child deaths of 17 per million of the child population in England and Wales in 2006<sup>31</sup>, Kent Police statistics indicate that between 1997 and 2009 there was a total of 27 murders and attempted murders of children in the county. This averages at two a year and if related to the under 18 year-old child population of the county, gives an incidence of 6 per million; nearly two thirds less than the national incidence.
48. **Referral rates** – In common with national trends, Kent has experienced a substantial rise in referrals to children's social services.

| <u>Year</u> | <u>Number of c&amp;f referrals</u> | <u>% Increase on previous year</u> |
|-------------|------------------------------------|------------------------------------|
| 2006/07     | 10,515                             | -                                  |
| 2007/08     | 12,005                             | +14%                               |
| 2008/09     | 17,360                             | +22%*                              |

[\* N.B. Prior to 2008/09 a family of children was counted as a single referral, from 2008/09 onwards, each child in a family has been recorded as an individual referral. This accounts for a proportion of the apparent increase in referrals and the percentage increase has been adjusted by Kent CSS to allow a fair comparison with the previous means of recording.]

49. Of all the children and families referrals received by Kent Children's Social Services in 2008/09, 47 per cent received an initial assessment. Of the 8,240 referrals that received an initial assessment, 51 per cent went on to have a comprehensive "core" assessment. At the year end, there were 1000 children who were assessed as being at continued risk of significant harm and were therefore subject to a child protection plan.
50. **Staffing and vacancy rates** – The national shortage of qualified social workers creates difficulties for all social services authorities in recruiting and retaining professional staff. The added pressures of child protection work make this specialism one of the less attractive areas of social work thus

<sup>31</sup> Quoted by Professor Colin Pritchard in British Journal of Social Work, Vol 40, No 2, March 2010.

compounding the problem. Despite active and imaginative recruitment initiatives, Kent experiences similar problems to other authorities in filling its children's social work establishment and in retaining staff in the highly demanding area of intake and assessment work. Illustrative of these difficulties is the variable vacancy rates in individual social work teams in the county. For example, at the end of January 2010, a number of teams (including some Intake and Assessment Teams) had 40 percent vacancy rates and there was a 29 per cent vacancy rate for all social worker posts. Through active recruitment measures, including the employment of social workers from the USA and northern Europe, the overall vacancy rate will drop to 21 per cent as soon as the new workers have completed their induction programmes. Despite the recruitment of overseas social workers and a continued programme of recruitment from social work training courses, the peaks in vacancy rates in individual teams coupled with the marked increase in referral rates places serious burdens on remaining staff which can present a potential risk to maintaining a safe child protection system.

51. **Lessons from Serious Case Reviews** – A recent review of 24 serious case reviews conducted by the University of Edinburgh<sup>32</sup> on behalf of the Kent Safeguarding Children Board indicates that many of the lessons from these serious cases are similar to those identified in national inquiries (see Paragraphs 15 - 18). The review drew attention to the recurrence of some recommendations from the reviews and the common themes of the difficulties in maintaining focus on the needs of children when working with what are often manipulative, intimidating, and hostile parents. The need for adequate resources and training was stressed for all agencies.
52. The lessons and recommendations identified by the serious case reviews undertaken by the Kent Safeguarding Children Board are of vital importance to the delivery of a sound child protection system. It is essential that all agencies should give the highest priority to any recommendations concerning their service and should ensure that individual professionals and their organisation as a whole learns the lessons from these reviews. The presence of repeated recommendations suggests there is room for improving the implementation and accountability processes. Although the Kent Safeguarding Children Board is responsible for monitoring the responses to serious case reviews, wider communication of the agency responses and actions will assist in raising the understanding and engagement of professional practitioners, management boards, and elected Members, where they are involved. A significant benefit has been gained from conducting special seminars within agencies and on a multi-agency basis

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<sup>32</sup> "An Analysis of Serious Case Reviews Undertaken by Kent Safeguarding Children Board" September, 2009.

when previous reviews have revealed important lessons. Consideration should be given to the introduction of seminars after each review to ensure the lessons are properly disseminated. Consideration should also be given to presenting an annual report to the County Council which will summarise the year's reviews, their recommendations and actions taken in response by each agency

53. Whilst periods of change bring opportunities, they also bring the risk of losing focus on individual social work cases. It is for this reason that a strategy is necessary for the preservation and development of a sound level of child protection social work.

**A Kent strategy for defending and developing**

54. In seeking to ensure that children are properly protected, it is important to stress that in comparison with the majority of other nations, the United Kingdom is a relatively safe place for children. Furthermore, Kent has a child homicide rate which is substantially lower than the national average. Nevertheless, maintaining and improving that level of safety is not easily achieved and it is necessary to maintain constant review of the service. In the situation where details of the resource implications and the timetable for implementation of the Social Work Task Force recommendations have yet to be established, it is proposed that the main aspects of a strategy to defend and develop Kent's child protection service should concentrate on two elements:

1. Supporting social workers in performing their current responsibilities
2. Preparing Kent Children's Social Services for the future

55. The first element needs to take account of the findings of the earlier stages of this review and the universal factors identified earlier in this report. These three sets of findings can be aggregated and interpreted as the following main areas of pressure:

- Resources
- Demand
- Quality of assessment and intervention

56. **Resources** need to be adequate to meet demands. This entails having sufficient professional social work staff plus administrative and managerial support to meet the demands of current and new referrals to Children's Social Services and to have reliable systems for receiving and responding to referrals. This includes all forms of existing cases and referrals, not just where

children are at risk of abuse or neglect. This is necessary if cases of “need” are not to deteriorate and demand more complex, expensive, or traumatic interventions. In the current national shortage of qualified and experienced children’s social workers, monitoring vacancy rates (particularly in intake and assessment teams) and having effective staff recruitment and retention programmes is an essential element of the strategy. The current monitoring and reporting processes should be continued, kept under regular review, and action taken where shortfalls are identified.

57. The adequacy of administrative support should also be the subject of regular review in order to ensure that professional social work time is directed at core social work tasks rather than administration. Progress has been made locally and nationally by improvements to computerised data systems (the Integrated Children’s System which has been the subject of considerable national criticism) and delegating some input tasks to clerical staff. However, the percentage of professional social workers’ time spent on administrative tasks (e.g. completing forms and inputting and updating electronic records systems) continues to be high. Although precise measurements are not readily available, this is estimated to be as high as 80 per cent, leaving only 20 percent for direct client contact. Means of reducing administration and increasing client contact time should be the subject of continuing review and contact should be made with other local authorities to share experience in this field and, where appropriate, to seek shared solutions through the joint development of efficient, casework oriented, and user-friendly information technology programmes.
58. **Demand** from existing social-work caseloads and from new referrals requires monitoring and managing. Although the initial phase of this review indicated that nearly all active child protection cases are allocated to a social worker and the response to new referrals is appropriate and timely, attention was drawn to the effect that sudden and unpredictable staff absence or vacancies can have in individual teams. Temporary resource deficiencies may coincide with localised peaks in demand necessitating special measures, including prioritising and deferring the allocation of less urgent referrals. In order to ensure appropriate prioritisation and review of any changing circumstances affecting individual cases which may be pending allocation, it is essential that sufficient information is provided by referrers and where this is lacking, action is taken to gather it and to review it regularly. Management processes should be reviewed to ensure there are robust systems for prioritising, and for the frequent monitoring and review of all unallocated cases.
59. Safe and efficient prioritisation is considerably facilitated if referrals are clear and if referring agencies understand and are confident in the thresholds for referral established by Kent Children’s Social Services and the Kent

Safeguarding Children Board. This element of the strategy for the management of demand should be closely linked with the work of the Kent Safeguarding Children Board in the establishment of agreed thresholds, promoting the use of the Common Assessment Framework, and the improvement of referral standards through inter-agency training programmes.

60. **Ensuring prompt and adequate responses** to referrals and concerns from professionals and members of the public depends on robust intake systems that are readily accessible and engender confidence in the referrer and in the professional social workers engaged in first-line responses (including out of hours). Kent has been innovative in establishing a co-ordinated system for receiving referrals and directing them to appropriate duty and assessment teams both in normal office hours and out of hours periods. Inevitably, increasing referral rates for services to both adults and children have placed pressure on this process and continued monitoring and quality control is necessary to ensure the prompt, safe and appropriately prioritised response to all new referrals. The Kent Contact & Access Service (KCAS) is based at Kroner House in Ashford, operating between the hours of 8am and 6pm, taking referrals for Kent Adult Social Services (KASS) and Children's Social Services (CSS). Contact Kent is a 24/7 service, based at Invicta House in Maidstone, providing the initial contact point for all County Council services. The only other dedicated 24/7 public contact services in Kent are those operated by the Police and NHS Direct. Recent reviews of the two KCC call centres – KCAS for social services (both adult and children's services) in Kent and the Contact Kent service - have indicated a discrepancy between the two services in their response potential for new referrals. Concern has been expressed regarding the number of abandoned calls to KCAS (between 15-20 per cent, compared to a national benchmark of 2 – 5%) and occasional backlogs of referrals which may take up to five days to be processed and forwarded to the appropriate social work team. Both the KCAS and Contact Kent need to have a dependable and fast throughput of referral which has the confidence of the social work teams which will be responsible for undertaking assessments or emergency interventions. Continued review and action is required to reduce the abandoned call rate to the 5 per cent standard considered acceptable by most commercial and public call centre services. (Achieving a lower rate is probably impossible as a percentage of callers will change their minds in the process of telephoning.) Consideration is currently being given to further developments in the call centre services of all public agencies in Kent with a view to establishing an integrated system where fast and seamless transfer of calls can be established between agencies. As this is likely to further increase demands on response times, it will be essential for further review and action to minimise delays and abandoned calls. It is suggested that the abandoned call rate in KCAS may pose a potential risk and that this is an issue that can be best tackled through the post Total Place

activity examining the opportunities to move from separate and stand-alone to wholly integrated public access and contact systems. It needs to be appreciated that specialist services need to be better integrated into the multi-agency Gateway developments, exploiting multi-channel access as it is further rolled out.

61. **The quality of assessments and interventions** is a vital aspect of safe child protection practice. Good quality child protection assessments and decisions are dependent upon having suitably qualified and experienced social workers available to meet demands and their having the capacity to complete the often complex tasks involved in child protection work, including time-consuming court processes. However, the nature of child protection work is such that having sufficient professional resources to meet demand is, in itself, not a sufficient condition to guarantee high quality work. It must be acknowledged that social-work intervention is not welcomed in many of the families where there is the risk of child abuse or neglect. Professionals are met frequently with hostility, including threatened or actual physical assault. Parents may be reluctant to comply with child protection plans or they may disguise their non-compliance. Inevitably, there is the risk that the chaotic lifestyles of some families may be reflected in the management of the case and pressures from one difficult case on an individual social worker's caseload may impinge on the other cases. These factors have been recognised as contributing to the failure to protect many of the children that have been the subjects of serious case reviews or public inquiries.
62. The most effective means of ensuring good professional practice on individual cases is undoubtedly by means of "reflective practice" as described by Lord Laming.<sup>33</sup> His contention that "the tradition of deliberate, reflective social work practice is being put in danger because of an overemphasis on process and targets, resulting in a loss of confidence amongst social workers" has been accepted by government and is reflected in Recommendation 7 (see Paragraph 41) of the Social Work Task Force report which requires the provision of regular, high-quality, organised supervision which is "open, supportive, focusing on the quality of decisions, good risk analysis, and improving outcomes for children rather than meeting targets". Meeting this requirement demands that both supervisors and practitioners have the time and opportunity to devote to this very necessary activity. It is encouraging that Kent Children's Social Services has a robust supervision policy aimed at achieving Lord Laming's and the Task Force intentions. This policy was introduced in 2007 and is due for review in 2010. It is strongly recommended that the policy review is given high priority and a report of its effectiveness and

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<sup>33</sup> Lord Laming, "The Protection of Children in England: A Progress Report", HMSO, 2009

any identified needs for amendment or improvement are brought to the attention of senior management at an early date.

63. Due to the wide range of difficulties which may be present in child protection cases, it is also essential that the skills and knowledge of managers and practitioners should be kept up to date by means of personal professional development programmes and training. A child protection social worker may be required to respond to cases involving many complicating factors (e.g. organised abuse, Internet pornography, domestic violence, drug and alcohol abuse, fabricated or induced illness, etc.) and it is vital that their knowledge and skills should be maintained and developed through appropriate training mechanisms. Meeting the varied training needs of a large professional workforce will demand a flexible approach to training methods which should include the development of electronic and interactive programmes that can be used within the workplace for team development and learning. This too, will require adequate resources to finance the requisite training and to release staff to attend training.
64. An adjunct to supporting social workers in achieving good quality work through supervision and training is the quality assurance and audit programmes that maintain a regular appraisal of the overall standard of practice and performance. Kent Children's Social Services has an established and effective monitoring programme that is sufficiently flexible to respond to emergent factors which may be affecting the standards of child protection work. This has been amply demonstrated by the committed and efficient support given to this review by the quality assurance section of Kent Children's Social Services. The continued and robust appraisals undertaken by this section will be an important element of the strategy for defending and developing child protection work.
65. **Preparing Kent Children's Social Services for the future**  
Preparing for the future cannot be approached in isolation from steps that are necessary to preserving a good standard of service in the present. Many of the steps will be identical, only differing in the time needed for implementation. Foremost among actions that will be essential to maintaining the service will be achieving high levels of occupancy of professional social work posts coupled with stability in the workforce. The former will be dependent on a recruitment strategy that is able to present Kent as a professionally attractive employer with good career development opportunities and good staff support systems. Attention to the general elements of the proposed strategy for defending and developing the service, together with action on the specific recommendations of this report will go far in maintaining Kent's positive profile as an employer.

66. Due to the national shortage of qualified social workers and the relatively slow process of adding to the total number in the professional “pool”<sup>34</sup>, additional measures will be necessary to achieve the desired professional occupancy rate. Previously, the county has had considerable success in attracting and developing unqualified individuals with the appropriate potential through trainee schemes, including financial assistance through college courses. The experience of these schemes has been positive in that they have added to the numbers of qualified social workers in the county, many of whom have remained and achieved senior positions. Positive consideration should be given to re-establishing and developing trainee schemes.
67. The number of places available on social work training courses is a limiting factor in the availability of qualified social workers. If the national pool is to grow not only to match the service requirements but also to replace those who have reached retirement age or who have been promoted into senior management positions, the numbers of places on training courses will need to increase. Although this is a national problem, most appropriately met with national solutions, it is possible to gain local advantage through a system of bursaries or county sponsored places on training courses. An initiative of this nature would complement the trainee initiative (see Paragraph 66) to the advantage of training courses, individual students, and the county’s professional workforce.
68. Attracting and developing a professional workforce will only be successful if once engaged, individuals have sufficient job satisfaction and career prospects to induce them to stay. Although an element of staff turnover is inevitable and helps guard against organisational complacency, there are sound professional reasons for establishing stability in the professional workforce. The effectiveness of social work intervention with individuals and with families is considerably enhanced when there is continuity and stability in the professional relationship. High turnover of professional staff results in the regular and rapid change of social workers on individual cases: changes which may hinder progress and which are frustrating and time consuming with each new worker having to “start again” on the case. A stable workforce is more likely to be effective, efficient, and economical.
69. Important contributory factors in workforce stability include good professional support and development prospects. Attention has already been drawn to the vital role of good and regular professional supervision in supporting social workers (see Paragraph 62). It is essential this is maintained as the central pillar of the support given to social workers now and in the future. Complementary to the role of supervision, is the development of knowledge

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<sup>34</sup> It takes three years to complete a social work training course and there is the probability of the introduction of a year’s post-qualifying probationary work before being granted full professional status. There is also a limit to the number of places available on training courses.



and skills through training. Although the quality of social work training is kept under regular review, and the basic three-year course provides a foundation for social work in a wide range of settings, working with families where children are at risk of abuse requires a high level of skill and experience which cannot altogether be provided within the work setting. Specialist training courses are necessary to maintain and develop skills. Social workers will need to have the time available to attend appropriate courses and there needs to be the organisational capacity to enable the integration of new skills and knowledge within individual caseloads and within the wider operational and policy structure of children's social services.

70. A programme of professional training and development obviously needs to meet the needs of the service as well as contributing to individual development. In the past, the county has profited from close links with centres of academic excellence in developing specific training, development and research initiatives (e.g. Birmingham University and specialist training in mental health following the introduction of the 1989 Mental Health Act 1983, Dartington Social Research Unit and services for children in need and child protection). Within Kent, the authority has worked closely with the University of Kent and Christ Church University. Further afield, the authority has established training links with European counterparts and with Harvard in the USA. It is proposed that similar partnerships be established to meet the needs of the demands of child protection work. In acknowledgement of the importance of the need for close co-ordination of the various professions contributing to the safe care of children, training initiatives should not be restricted to social workers but should include other specialists and form a major element of the qualifying and post-qualifying training of professionals in the police service, teaching, health visiting, midwifery, and nurses and doctors in general practice and in accident and emergency units.
71. A particular demand of child protection work for all professionals is the ability to make good assessments and to implement effective child protection plans when dealing with difficult parents and carers who may be aggressive, manipulative, and devious in their attempts to conceal abuse or who give a misleading impression of co-operation. National child protection inquiries and serious case reviews have drawn attention to the need for "respectful uncertainty" (stressed by Lord Laming in his report and recommendations following the death of Victoria Climbié in 2003) however, developing the professional skills and resilience to maintain focus on a child's welfare in the face of obstructive and misleading parents or carers is one that takes time. However, it is such an important aspect of good child protection work that it should be given a very high priority. Consequently, among the training programmes that should be developed through links with academic institutions, it is proposed that emphasis be given to specialist training in

dealing with difficult families. To be effective, this needs to be skill based rather than purely theoretical and there is considerable merit in establishing a specialised training centre equipped with video technology where the whole range of professionals who may be involved with such families can develop skills through role-play with actors and review and appraise their attempted interventions (this model makes an important contribution to the development of skills for emergency workers dealing with major disasters and is likely to have similar advantages for skill development in child protection). The Chief Executive of Kent County Council has had exploratory discussions with the University of Kent and Christchurch College who have expressed their support for the establishment of this facility and Kent Police have indicated their willingness to explore the possibility of sharing their assets and the financial and practical responsibilities with social services. Further inquiry should be undertaken with other agencies with a view of establishing a truly multi-professional training centre.

72. Attracting and retaining qualified professional social workers is also dependent on how the county's practical commitment to professional social work values is perceived by existing and potential employees. Kent has a good record of commitment in this respect and many of the initiatives previously mentioned have contributed to a sense of sound social work values underpinning all levels of the service. However, delivering social services in the largest local authority in England involves a range of management responsibilities where economy, efficiency, and wider political considerations have to sit alongside professional social work values. In order to maintain an effective professional appraisal and input to both the management and the political governance affecting child protection and other aspects of social work in the county, there needs to be robust mechanisms for providing advice and alerts to senior managers and to elected Members and which will also provide reassurance to social workers that their professional values and ethics are being promoted and safeguarded.

*Such measures should be part of a series of checks and balances including those that are currently provided by monitoring and quality assurance measures within children's social services and the overview responsibilities of the Kent Safeguarding Children Board. It is recommended that the overall process should be clearly identified and should include professional advice to those senior executive members of the county council who are individually accountable for the effective delivery of social services (including child protection), i.e. the Leader and Chief Executive. It should also be a clear indicator to the professional social work force that their professional status is valued and is a major factor in the shaping and delivery of services.*

### Summary

73. The preceding sections of this report have outlined the factors which will be important in preserving and advancing good child protection practice within Kent Children's Social Services. A strategy for defending and developing child protection work will provide a sense of direction that will enable a balanced approach that will avoid the risks of over-reaction or over concentration on high profile aspects. The strategy should address the following strategy objectives:

| STRATEGY OBJECTIVE  | PARAGRAPH REFERENCE |
|---|---------------------|
| Ensuring Kent Children's Social Services provides a prompt and effective response to all new referrals  | 2, 56, 60           |
| Improving multi agency collaboration and understanding at agency management level and at practitioner level   | 9, 51, 59, 60       |
| Ensuring lessons from serious case reviews and their recommendations are given the highest priority in all agencies   | 18, 52              |
| Ensuring adequate resources to meet the needs of all children failing to meet the <i>Every Child Matters</i> outcomes as well as children who are at risk of significant harm | 26, 27, 36, 56, 59  |
| Ensuring the balanced introduction of new policies and initiatives  | 32, 36              |
| Ensuring a high standard of reflective professional supervision for social workers and protecting the time available for this   | 38, 62, 69          |
| Achieving a positive work environment which is conducive to good social work practice   | 43                  |
| Ensuring workers from all agencies have the skills to work with difficult, aggressive and manipulative parents and carers and to maintain focus on the needs of the children  | 51, 69, 71          |
| Ensuring there are high levels of occupancy and stability in the professional social worker establishment   | 65                  |

74. Although the above table contains the basic elements of a strategy for maintaining and developing child protection services, it should not be considered as definitive. Its individual elements and its total objectives should be the subject of regular review and it should be amended and adapted to meet changing circumstances. This review should take place annually and include a progress report on previously identified recommendations and objectives.

### **Recommendations**

75. The following specific recommendations are considered to be important steps to defending and developing child protection services in Kent. Members are recommended to approve:
- 75.1 The main elements of the proposed strategy should be the basis for further detailed review and refinement by the **Managing Director of Children, Families & Education, the Director of Specialist Children's Services** and their staff, including an analysis of the national reports published on 18 March 2010.
  - 75.2 The **Kent Safeguarding Children Board** should give positive consideration to undertaking a multi-agency peer review of a sample of current child protection cases to assure itself about practice standards across agencies. (See Paragraph 20)
  - 75.3 The **Kent Safeguarding Children Board** should identify and report on steps taken to improve the culture of openness and exchange between member agencies and its actions to establish greater accountability to the KSCB for child protection standards within member agencies. (See Paragraph 21)
  - 75.4 The **Kent Safeguarding Children Board** should present an annual report to the Kent County Council and other relevant public bodies. (See Paragraph 22)
  - 75.5 **Kent Children's Social Services** should make regular use of the Social Work Task Force's organisational self-appraisal tool to ensure it is achieving high standards as a social work employer. (See Paragraph 43)
  - 75.6 The **Kent Safeguarding Children Board** should, as a standard practice, deliver multi-agency seminars and targeted training following every serious case review to ensure that the lessons from the reviews are quickly and efficiently promulgated. (See Paragraph 52)
  - 75.7 **Kent Children's Social Services** should maintain a continuous review programme to ensure the adequacy of administrative support services and systems for social workers with a view to reducing professional social work time spent on administration and increasing the direct client contact time. (See Paragraph 57)

- 75.8 **Kent Children's Social Services** should establish partnerships with other local authorities to share approaches aimed at minimising the administration workload of social workers and to seek shared solutions through the joint development of efficient, casework-oriented, and user-friendly information technology programmes. (See Paragraph 57)
- 75.9 **Kent Children's Social Services** and the **Kent Safeguarding Children Board** should ensure a good standard of referral information through training programmes and quality assurance audits with partner agencies. (See Paragraph 58)
- 75.10 Urgent action should be taken by **Kent Children's Social Services** to reduce the rate of abandoned calls to the Kent Contact and Assessment Service. (See Paragraph 60)
- 75.11 **Kent Children's Social Services** should give high priority to the current review of their staff supervision policy with the objective of making professional social work supervision a guaranteed and protected element of the service with protected time for practitioners and supervisors. (See Paragraph 62)
- 75.12 The **Kent Safeguarding Children Board** should develop in partnership with appropriate academic and other training institutions electronic and interactive training packages that can be used for workplace training and team development of skills necessary for child protection work across and specific to agencies. (See Paragraph 63)
- 75.13 **Kent Children's Social Services** should establish a trainee scheme for suitable candidates for professional social work training and provide financial assistance through training professional training in return for a contractual commitment to remain in employment with the county for a minimum of two years after qualifying. (See Paragraph 66)
- 75.14 **Kent Children's Social Services** should seek to establish a number of bursaries or sponsored places on suitable social work training courses. (See Paragraph 67)
- 75.15 **Kent Children's Social Services** should establish close partnerships with suitable centres of academic excellence to develop training and research programmes that will meet the demands of child protection social work. (See Paragraph 70)
- 75.16 The **Kent Safeguarding Children Board** and **Kent Children's Social Services** should develop training initiatives that will ensure that all

professionals in the course of their qualifying training have joint training modules to increase the shared professional understanding of child protection work and to establish a core of inter-professional skills and knowledge. (See Paragraph 70)

75.17 **Kent Safeguarding Children Board** and **Kent Children's Social Services** should seek to establish a multi-agency specialised training unit within the county aimed at developing the necessary skills for working with difficult uncooperative families. (See Paragraph 71)

75.18 **Kent Children's Social Services** should establish robust mechanisms for providing advice and alerts to senior managers and to elected Members and which will also provide reassurance to social workers that their professional values and ethics are being promoted and safeguarded. (See Paragraphs 72 and 73)

75.19 **The Leader and Chief Executive/Group Managing Director** should arrange with the Director of Children Services, the Director of Specialist Children Services and the independent Chair of the Safeguarding Board an annual programme of reporting to Cabinet and full Council, to provide an open and systematic approach to quality assurance. This programme should be managed through Corporate Policy and supported with advice from a reference group comprising frontline practitioners. (See paragraphs 72 and 73).

# Annex A:

## Organisations and workloads

The Social Work Task Force believes that the people who organise, deliver and receive services are ultimately best placed to understand how local services should work. However, when seeking to make improvement, it can be difficult to find the best starting points for analysis and then action.

As discussed in Chapter 2 of this report, we are presenting an initial framework for helping employers and practitioners to take action now in assessing the “health” of their organisation on the range of issues affecting workload. This framework should be developed further in due course in support of the proposed standard for employers.

The framework looks at 5 key areas which we know all make a significant contribution to the development and delivery of excellent services.

The framework is to support organizations to undertake a self assessment against the 5 areas, identify current strengths and plan to tackle areas for improvement.

The framework is not designed to act as a check list, but as a mechanism to promote debate at all levels of the service.

It can be used at team, service and organisation level. It should be the basis for discussion at each of these levels, with a requirement in place that staff have been involved in the response at each level and a mechanism for recording areas of disagreement. Where this is identified, a mechanism for reviewing the assessment, usually by a manager of another team or at a higher level, should be included.

Each organisation should also clarify how frequently they will undertake a “health check” and what the process for audit and reporting should be, including at least an annual report to lead member for both adult and children’s services.

The framework is not designed to be prescriptive and can be adapted to meet the needs of each organisation. However, the following prompts may be of use in promoting analysis and debate:

### Effective workload management

Vacancy rates – including

- current unfilled posts
- posts covered by agency/temporary staff
- posts which are filled but where staff are absent (e.g. long term sick, maternity leave)
- turnover rates

Workload – including

- numbers of cases held by each full time equivalent
- average hours worked by staff on a weekly basis
- current levels of TOIL and leave to be taken by team members
- number of supervision sessions which have taken place – is this in line with organisational policy?
- staff attendance at CPD opportunities as planned in performance appraisal – how often is training cancelled/re arranged?
- additional responsibilities e.g. student on placement, acting as mentor to other team member, undertaking action research

### Pro active workflow management

- Number of unallocated cases
- Re-referral rates
- Changes in workflow over time (peaks and troughs)
- How unallocated cases are risk assessed
- The escalation process for unallocated cases and alerts to senior managers
- How many cases are allocated to the team/manager/duty
- Delays in transfer of cases between teams
- How often workers are required to cancel meetings with people who use services/other professionals in an average week due to re-prioritisation of work
- Specific blocks to work flow which need to be considered e.g. efficiency of commissioned services, relationships with other agencies, transfer between teams/services
- Is the most efficient use of skills being made within the team and wider service? Are social workers undertaking tasks for which their skills are primarily required or could they be done more effectively by someone with different skills e.g. an administrator, para professional or other professional group either within the service or via a commissioned arrangement?

### Having the right tools to do the job

- Access to equipment – mobile working, IT access including to the internet



- Access to professional services to support case work– translators, legal advice etc
- Access to resources e.g. research, library facilities
- Appropriate office space e.g. desk, office chair, access to quiet space.

### A healthy work place

- Is there a system in place to monitor frequency of supervision and quality of it in order to ensure effective practice is supported?
- Is 360 appraisal in place?
- Is there an employee welfare system in place and are staff aware of how they access it?
- How often do team meetings take place?
- Are staff able to contribute to the agenda?
- Are senior managers accessible/visible in the service?
- How are stress levels monitored on an individual and service basis?
- Is there a whistle blowing process and are staff aware of what this is?
- Are there processes in place to ensure staff welfare e.g. risk assessments of roles/activities, call back/monitoring processes to ensure safety whilst working away from the office base including out of hours?
- What are the sickness levels in the team/service and what is the pattern over time?

### Effective Service Delivery

- Findings from compliments, comments and complaints
- Feedback from service users
- Feedback from stakeholders/other professionals
- Staff survey results
- Exit interview analysis



**Version 1.1**

**CHILDREN, FAMILIES  
AND EDUCATION  
CHILDREN'S SOCIAL SERVICES  
STAFF SUPERVISION POLICY**

**Document Owner:** Policy and Performance Manager Safeguarding CP & CHIN

**Authorised:** April 2007

**Review Date:** April 2010

**KENT COUNTY COUNCIL  
CHILDREN, FAMILIES & EDUCATION DIRECTORATE  
CHILDREN'S SOCIAL SERVICES  
STAFF SUPERVISION  
POLICY**

## **1. POLICY STATEMENT**

Kent County Council Children Families and Education Directorate and the Children's Social Services Division are committed to ensuring that every member of the social care work force receives good quality effective supervision on a regular basis. It recognises that delivering social care services is a complex and demanding task and that our staff are the key asset in delivering high quality services that make a real difference to our service users lives. In our view, supervision is an integral part of this delivery.

This policy aims to promote a positive, relevant and consistent approach to supervision and a clear framework within which to practice.

The following documents, policies and procedures underpin or connect with this policy and should be consulted as required:

1. KCC Business Plan – Towards 2010
2. Children and Young Persons Plan
3. Children's Social Services Annual Business Plan
4. CFE Recording and File Management
5. KCC Equal Opportunities Policy
6. KCC Policy regarding Bullying and Harassment
7. Staff Induction Procedures
8. Staff Authorisation Policy
9. Case sampling procedures
10. File recording Policy
11. Health and Safety Policy including Prevention and Management of violence to staff and the risk assessment process
12. People Management handbook
13. GSCC code of practice for social care workers and for employers of social care workers
14. DFES common core skills and knowledge for the children's workforce
15. Accountabilities and delegations policy and procedure.

## **2. DEFINITION OF SUPERVISION**

Supervision is defined as "a key place for decision making in social care". Hughes and Pengally 1997.

Within Kent Children's Social Services, the delegations and accountabilities policy outlines a clear structure of accountability for decision making within Children's social services and should be read alongside this document

Supervision will usually take place one to one, in a planned way but can also include group supervision, observation of practice and examination of records. It can also be a conversation between supervisor and supervisee in response to an unexpected task or event that cannot wait until the next planned supervision.

### **3. PURPOSES OF SUPERVISION**

The purposes of supervision include:

- To make and review clear and accountable decisions within casework.
- To ensure good quality case work that maintains a clear focus on the child and operates within agreed standards, timescales, policies and procedures.
- To offer direction, support, guidance and advice.
- To provide a protected space within which feedback is given, good work celebrated and mistakes recognised and rectified.
- To reflect on the personal impact of the work on the supervisee, recognising feelings engendered by casework can be an important tool for decision making, but also to take necessary action to alleviate stress and difficulty.
- To enable the supervisee to reflect and discuss any personal issues which may be impacting on their working life.
- To look at the overall workload to achieve a balance between various cases and the skills and abilities of the supervisee.
- To encourage learning and professional development, recognising the supervisee's learning style and training needs.
- To feed into the supervisee's personal development and action planning process through the Ways to Success and Total Contribution processes.
- To promote awareness of the wider social care agenda both nationally and within Kent County Council and ensure there is an understanding between the Business Plans and overall strategy and the supervisee's role and function.

### **4. OVERARCHING PRINCIPLES**

- The supervision of Children's Social Services staff will have high priority. Every member of staff has a right to regular planned, recorded supervision.
- Supervision will operate within the context of Kent County Council's Equal Opportunities policy. Every supervisee is entitled to fair and equal treatment and encouraged to develop and achieve their potential. Any disagreement between supervisor and supervisee in relation to any potential issues of discrimination regarding race, gender, faith, age or disability must be discussed by both parties with the supervisor's supervisor in the first instance.
- Similarly poor performance will be managed in an open and transparent way within the context of KCC's Performance Management procedures?
- The GSCC Code of Practice for social care workers and the DFES common core of skills and knowledge for the children's workforce will provide the explicit framework of core competencies against which the supervisee's performance will be measured.
- Supervision of qualified social workers must be undertaken by a suitably qualified practitioner at a senior level who is experienced in casework, including child protection, and who has undertaken some formal training in supervision.

- Supervision of differentially qualified staff, for example social work assistants, should also be undertaken by a suitably experienced and qualified practitioner, but this may be a less senior person within a district, for example, a social worker who is keen to develop supervisory skills and experience. In these circumstances it is for the district manager to approve the arrangement and ensure that the proposed supervisor has the necessary skills and support to undertake supervision.
- Supervisors are accountable for the appropriate level of decision making, for overseeing the quality of the casework and the achievement of organisational objectives.
- Within the supervision of staff who are undertaking additional pieces of work, rather than caseholding, the overall responsibility for case work decisions rests with the caseholder and their supervisor and arrangements must be put in place to ensure that communication between the workers and the supervisors takes place in the way outlined for co-working relationships later in this document.
- Every supervisee must take responsibility for their own performance and learning, ensuring it is integrated into their everyday practice.
- The extent and limits of confidentiality within the supervisory sessions will be discussed, agreed and recorded. Situations where there is an unmanageable risk to any person, issues of breaches of the law or contract will be reported. It is expected that the Line Manager will have access to the supervisory records and will review the supervision process within their own supervision with the supervisor.
- A process for handling complaints and disagreements within supervision will be discussed, agreed and recorded. This will usually involve an agreement to involve the supervisor's Line Manager in a 3-way discussion to resolve any issue that the worker and supervisor cannot resolve themselves
- Where a case is being co-worked, particularly if this is across teams, for example between the Disabled Children's Team and Children & Families Team, it is important that both workers and both supervisors meet together every 2-3 months as a minimum for joint supervision. This arrangement would be in addition to the normal communication that would take place between the workers

## **5. MANDATORY PROCEDURES**

- Every member of staff will have an individual supervision contract with their supervisor, subject to an annual review. A formal contract confers importance and status to supervision. The contract will detail frequency and duration of supervision, practical arrangements, agendas, content and dates for review. A suggested format is attached as appendix i.
- The frequency of supervision will be discussed and agreed between supervisor and supervisee and will take into account the skills, abilities and experience of the supervisee and the level and demand of the work for which they are responsible. Newly qualified staff should have weekly supervision for 6-8 weeks, moving to fortnightly thereafter until the end of their first year. Experienced staff should have supervision 3-4 weekly, with a minimum of 1 and a half hours every 4 weeks.
- Additional, unplanned supervision will be available to allow for emergencies or pieces of work that require immediate discussion. All decisions from the

discussions will be recorded on running record by the supervisor or supervisee and captured at the next formal supervision session recording

- Individual supervision should be private uninterrupted time, that is a priority for both supervisor and supervisee. Dates and times should be planned in advance and should not be changed or cancelled without an alternative time being made immediately.
- The supervisor is responsible for recording the content of the supervision. Case Work decisions should be recorded using the agreed format – see appendix ii – and signed by supervisor and supervisee. A copy should be placed on the service users' file. Supervision records in their entirety should be kept in a confidential place and passed to the next supervisor if supervision arrangements change within the district. Supervision records should be archived with the personnel records when a social worker leaves the district whether for a post within Kent or outside it.

The supervisor and supervisee are responsible for jointly drawing up an agenda for supervision and for ensuring this is adhered to within the session.

Both supervisor and supervisee have a responsibility to prepare for supervision. This may include drawing together current information on cases, reflecting on current progress and barriers to learning, identifying training needs, reading new policies or procedures, identifying new research or other material which may be relevant.

- Supervisors should ensure that running records are read and signed off and that every case file is subject to a minimum annual review by the supervisor and audited using the agreed tool – see appendix iii – which will then be placed within the file.
- Every member of staff will have a personal development and action plan in accordance with the CFE Directorate's Performance Management Scheme, Ways to Success and Total Contribution. This plan will be drawn up and reviewed within the timescales laid down.
- The content of supervision will cover each of the following topics on at least a quarterly basis, recognising that the emphasis on each will vary according to individual need.
- Review of case work, ensuring each open case is reviewed at least every two months.
- Review of the impact of the work on the supervisee
- Review of written files and records.
- Awareness and understanding of relevant research, policy, procedures and standards.
- Review of individual professional development.
- Feedback on training and learning opportunities.
- Review of supervisory relationship.

## **6. RESPONSIBILITIES OF SUPERVISOR, SUPERVISEE AND LINE MANAGER**

Supervisor and supervisee share a joint responsibility for the supervisory relationship which should be based on mutual respect and trust and where both feel able to question and challenge assumptions and decisions.

In addition the Line Manager – who may be the Team Leader or District Manager – is responsible for ensuring:

- That all members of staff are receiving good quality regular supervision.
- That training and development opportunities are identified, facilitated and evaluated.
- That supervision records and personal development and action plans are in place, are held confidentially but available, if required, for audit purposes.
- That all files have been audited by the supervisor on an annual basis, as a minimum.
- That policies, procedures and standards are effectively communicated.
- That an open culture of learning and development is promoted, where good practice is celebrated and mistakes are used to learn and develop.

## **7. USE AND REVIEW OF THIS POLICY**

- All newly appointed staff should receive this policy as part of their induction process.
- All newly appointed managers should have the opportunity to read and renew this policy as part of their induction.
- All in house training courses on supervision should use this policy as a basis for the standards and practice of supervision with Children's Social Services.

**AUTHOR Kathryn Lambourn**

**DATE APRIL 07**

**IMPACT ASSESSMENT SCREENING APRIL 07**

**REVIEW APRIL 2010**



**SUPERVISION AGREEMENT**  
**THIS AGREEMENT IS DRAWN UP BETWEEN \_\_\_\_\_**  
**AND \_\_\_\_\_**

1. Supervision will take place in private and be uninterrupted.
2. Supervision will take place – frequency and duration – and will be planned in advance. Every effort will be made not to cancel planned sessions but if this does happen, then an alternative date will be made immediately. Reasons for cancelling supervision should be recorded.
3. Supervision notes will be by the supervisor and a typed copy given to the supervisee. Both parties will sign supervision notes, which will be held in a secure place. Notes relating to specific cases will also be placed on the service user's file.
4. Formal supervision will not reduce opportunities for additional discussion on important matters that are between planned sessions. Any decisions taken in the meetings will also be recorded by the supervisor or supervisee on a running record and captured in the next formal supervision recording in the way outlined above.
5. Both supervisor and supervisee have a responsibility to come prepared for supervision with a clear picture of what they wish to discuss in the session.
6. An agenda will be drawn up at the beginning of each supervision session. Over a 3 month period, supervision will cover all of the following topics:
  - Review of case work
  - Review of the impact of the work on the supervisee
  - Feedback on review of written files and records seen as part of annual audit
  - Discussion of relevant research, policy, procedures and standards
  - Review of individual professional development
  - Feedback on training and learning opportunities
  - Review of supervisory relationship
7. In the event of any disagreement between supervisor and supervisee which they cannot resolve, the issue will be referred to the supervisors Line Manager and discussed in a 3 way meeting.
8. Supervision notes will be shared with the supervisors Line Manager and the supervision process discussed in the supervisor's own supervision. Within these boundaries, supervision is confidential between supervisor and supervisee unless there are implications for the personal safety of any person or breaches of the law or contract.
9. This contract will be renewed annually. The next date of review is

Signed \_\_\_\_\_

Date \_\_\_\_\_