Appendix 1

KENT SAFEGUARDING REVIEW 2009

PHASE I

ANALYSIS OF RESPONSES TO SAFEGUARDING QUESTIONNAIRE

Introduction

1. Following the death of Baby P, a Joint Area Review (JAR) of Haringey's children's safeguarding services was completed in November 2008 which identified serious shortcomings. These were summarised in a letter from Ed Balls, Secretary of State for Children, Schools and Families, to all Directors of Children's Services on 1 December 2008.

2. The JAR identified the following concerns:

    - Weakness in safeguarding and child protection procedures and practice
    - Inadequate leadership and management of safeguarding by local authority and partner agencies
    - Poor gathering, recording and sharing of information
    - Failure to identify those children and young people at immediate risk of harm
    - Poor child protection plans
    - Agencies generally working in isolation from one another and without any effective co-ordination
    - Failure to consult with children in some cases and where a child has not been seen alone, limited evidence of addressing the reasons for this and enabling the child's voice to be heard
    - Inadequate serious case review of the death of Baby P

3. The Secretary of State requested all children's services authorities to review their own safeguarding practices and to take action to remedy any similar, or newly identified shortcomings. As part of a comprehensive review of Children's Social Services (CSS) and inter-agency safeguarding practice in Kent, a questionnaire based on the findings of the Haringey JAR was sent to all CSS teams.[1] The responses to the questionnaire are reported and analysed in this report.

Findings

4. The questionnaire asked for 48 points to be considered. These points were linked to specific findings in the Haringey Joint Area Review. In general, the responses indicated that most elements of the CSS child protection process are considered safe or that action is currently being taken where the need for development or improvement has been identified.

[1] The questionnaire is contained in Appendix A of this report.

5. In some instances, responses indicate that certain elements of the child protection process are in need of attention, although this should not be read as saying that they are unsafe.

6. The questionnaire sought to establish the views of managers and practitioners on the following areas of practice:

    - Identifying and responding to safeguarding concerns (Questions 1 – 6)
    - Quality of recording and assessment (Questions 7 – 17)
    - Effectiveness of inter-agency co-ordination (Questions 18 – 26)
    - Service management (Question 27)
    - Performance management (Questions 28 – 37)
    - Workforce development and recruitment (Questions 38 – 46)
    - The Integrated Children's System (ICS) for computerised case recording and management

7. Details of the responses to each question together with illustrative comments from respondents are contained in Appendix B of this report.

Identifying and responding to safeguarding concerns

8. Responses to the questions dealing with this aspect of safeguarding indicate the following positives:

    - Thresholds are clear (Question 1)
    - Gathering information is generally satisfactory (Question 2)
    - Cases are almost always allocated to a qualified social worker (Question 5)
    - Electronic allocation is normally only done after discussion with the identified social worker (Question 6)

9. Responses indicated that improvements are required in the following elements of safeguarding:

    - Referrers are not often given written notification of action taken in response to the referral (Question 3)
    - Cases are often allocated to team managers pending allocation to a social worker (Question 4)

Quality of recording and assessment

10. Responses to the questions dealing with this aspect of safeguarding indicate the following positives:

- Children are seen and spoken to (Question 12)
- Managers address reasons when children are not seen alone (Question 13)
- The quality of care planning and assessment is satisfactory (Question 15)
- Account is taken of historical concerns (Question 16)
- Information from other agencies is used in assessments (Question 17)

11. Responses indicated that improvements are required in the following elements of safeguarding:

- Case file recording is not considered satisfactory (Question 7)
- Management oversight and decision-making is not sufficiently evident from records (Question 8)
- Evidence of thorough, analytical, and reflective supervision is not evident from records (Question 9)
- Files are not as well organised as they should be (Question 10)
- Chronologies are not always compiled (Question 11)

Inter-agency work

12. Responses to the questions dealing with this aspect of safeguarding indicate the following positives:

- Child protection review conferences usually involve agencies in addition to CSS and police (Question 19)
- Police managers participate in strategy discussions (Question 20)
- Children are visited within expected timescales (Question 21)
- Child protection plans are clear about actions and who is to take them (Question 22)
- There is evidence that child protection plans are successful (Question 23)
- Children and young people are usually consulted and their views sought regarding their child protection plans (Question 24)
- There are robust procedures for placing children with relatives in emergencies (Question 26)

13. Responses indicated that improvements are required in the following elements of safeguarding:

- Strategy discussions do not often involve more than CSS and police (Question 18)

- Attendance of children and parents at child protection conferences is not always monitored (Question 25)

Service Management

14. The response to the question dealing with this aspect of safeguarding indicates the following positive:

    - Policies are generally well implemented and followed (Question 27)

Performance management

15. Responses to the questions dealing with this aspect of safeguarding indicate the following positives:

    - Results of qualitative audits are used to evaluate outcomes for children (Question 28)
    - CSS performance indicators are used to question and challenge quality of front-line practice (Question 29)
    - Audits are supported by clear, measurable action plans (Question 31)
    - A file is opened for each child in the family (Question 34)

16. Responses indicated that improvements are required in the following elements of safeguarding:

    - Due to past difficulties with data quality in ICS, internal audit reports may not have been as comprehensive as desired.
    - CSS management data is not always perceived as reliable data Inconsistencies are perceived between reported performance and reality (Question 3)
    - Cases identified for closure are not closed promptly (Question 35)
    - There is not always evidence of management oversight and decision-making on records (Question 36)
    - Accounts of case discussions are not always placed on records (Question 37)

Workforce development and recruitment

17. Responses to the questions dealing with this aspect of safeguarding indicate the following positives:

    - Criminal Records Bureau (CRB) checks are completed on staff (Question 38)
    - Employment and identity checks are made on staff (Question 39)

- Pending CRB clearance, staff are appropriately supervised (Question 40)
- There is not a high turnover of qualified social workers (Question 41)
- There is not a high reliance on agency staff (Question 42)
- Action has been taken to attract staff (Question 43)
- There is a clear protocol for transfer of cases to long-term teams (Question 46)

18. Responses indicated that improvements are required in the following elements of safeguarding:
    - Caseloads and their management present difficulties (Question 44)
    - Social workers' management of their caseloads is affected by having to complete work of staff who leave (Question 45)

ICS computerised recording system

19. Responses indicated that improvements are required in the following elements of safeguarding:
    - ICS has created difficulties for practitioners and managers (Question 47)
    - Managers appear not always to have given sufficient priority to resolving ICS problems (Question 48)

Responses of CSS focus group

20. CSS teams that responded to the questionnaire were invited to send a representative to a "focus group" meeting to discuss the overall findings. Unfortunately the first date for the meeting had to be cancelled due to severe weather conditions which would have prevented many from attending. The deferred meeting was held on 20 March 2009 which was attended by a total of only six participants, including team managers, senior practitioners, and independent chairpersons of child protection conferences. Discussion with this group elicited the following views:
    - Delays occasionally experienced in inputting by County Duty system.
    - A concern that episodic pressures on teams may cause some occasional lack of consistency of designating a referral as Child in Need or Child Protection.
    - Child protection cases are very occasionally and temporarily "farmed out" to other teams because of pressure on teams, in order to ensure continuity of direct work and case management.

- Consistent standards of professional intervention depend on good managerial oversight and supervision and at times of greatest pressure, time may not be available for this.

- Transfer of cases from duty teams to long-term teams can sometimes be delayed because of lack of capacity in long-term teams. This often entails a number of duty social workers dealing with the case with consequent risks associated with lack of consistency and case sensitivity.

- Generally, the standard of professional work and the pressures of work are experienced as being worse than the situation 12 months ago.

- Experienced social workers are tending to move out of child protection work (seeking positions in adoption, disabilities, and other less pressurised specialisms). Exit interviews should be conducted with all staff, including those moving to new posts within CSS, to find out what would induce them to remain in child protection practice.

- Staff retention is crucial. Successful incentives are not always monetary. Post-qualifying training opportunities are considered good in Kent. Newly qualified staff are well-supported in Kent.

- Social-work training does not properly equip newly qualified staff to undertake children and families work (e.g. some have not undertaken any statutory work before or during training).

- There are many very able and experienced social work assistants that could be a very good source of future trained social workers. There is a need to "grow our own" professional staff. Social work assistants often have family and financial commitments that discourage them from undertaking full-time social-work training: there is a need for financial support to help them through training.

- Experienced workers need less management time.

- Consultant practitioner posts are not necessarily seen as an advantage to practice as in the past they had seen substantial amounts of their time diverted towards dealing with complaints, with consequently less time available for supporting practice development.

- CSS audits add pressure to workers and managers. There is the possibility that they may hinder rather than enhance practice by adding to stress and not allowing time to implement identified improvements before undertaking the next audit.

- There is an unhelpful perception of a "blame culture" and audits and reviews need to be framed in a more positive way.

- The establishment of a Head of Social Work profession reporting to the Chief Executive is welcomed.

- District vacancy rates may not adequately reflect high vacancies in individual teams.

- DIAT teams are under considerable pressure of work.

21. The small size of the focus group poses the obvious question of how representative these views may be. However, it would be wise to give further consideration to many of the points raised.

CONCLUSIONS FROM QUESTIONNAIRE RESPONSES

22. The broad conclusions that can be drawn from the responses indicate that:

- Kent CSS safeguarding standards are generally safe.

- There are some pressures on the safeguarding systems and practice.

- Some pressures are county-wide; others are localised.

- Localised pressures may change location and focus over time.

- Where county-wide pressures coincide with local pressures there is increased risk that standards may become unsafe.

County-wide pressures

23. The responses to the questionnaire indicated that most teams are affected by pressures arising from:

- The current operation of the ICS system which affects the quality of records and management information and occupies social work time which otherwise could be spent in client contact

- Staff recruitment and retention

- Workloads

Localised pressures

24. Questionnaire responses indicated that some individual teams were particularly affected by pressures arising from:

    - High vacancy rates.
    - Demanding workloads, especially when complex cases are in simultaneous crisis.
    - Use of agency workers.
    - The above pressures lead to increased demands on managers and diminish the capacity for thorough, analytical, and reflective supervision

Discussion

25. A degree of caution is required in drawing conclusions from the questionnaire responses, which were made in late January/early February 2009 when the post Baby Peter media scrutiny was at its height. This also arises from the fact that the responses are subjective and that judgements may differ according to the nature of the work of the team. Similarly, it is possible that some responses represent a collective team response after consultation and others may represent the views of an individual manager.

26. Although the general standard of child protection work is clearly seen as safe, a broader and more dependable assessment will be possible when the findings of the questionnaire are considered with the findings of the extended child protection file audit that is currently nearing completion.

27. There is no doubt that the introduction of the ICS system has proved demanding and disruptive. It is likely that standards of recording on both paper files and on the computerised system had deteriorated. This poses risk in that information should always be comprehensive and current. It is acknowledged that this is a national problem and that Kent is giving priority to resolving problems wherever the system allows for local action.

28. The problems of the ICS system may also be responsible for the comments relating to the perceived unreliability of management data and reports (see Paragraph 16).

29. Based on informal discussions with managers and practitioners and with the focus group and from the responses to the questionnaire, it is apparent that CSS was working to the upper limits of its capacity at the time the questionnaire was being completed. Although the additional investment into frontline capacity from 2009/10 onwards will make a positive impact, this will not happen overnight. Inevitably, local pressures of staff shortages and a rise in referral rates will, at times, create demands that require temporary solutions which may include engaging agency staff or reviewing local priorities. This has to be achieved whilst maintaining a good standard of

professional intervention with existing cases. In order to achieve this, managers need to have adequate time to attend to both, i.e. responding to demand and maintaining standards on current cases. Much use has been made of the analogy of "the perfect storm" and although it has almost become a cliché, it may aptly be applied to child protection work in children's social services departments over the last 18 months. In a team that is normally working efficiently and providing good safeguarding standards, the combined pressures of vacancies or absences due to sickness, a sudden peak in demand, and a number of current serious cases in simultaneous crisis, can create circumstances where there is an increased potential for misjudgements, mistakes, or poor practice.

30. In his response to the recent publication of Lord Laming's review of child protection practice[2], the Secretary of State for Children, Schools and Families stated that "None of Lord Laming's proposals alone could have prevented the death of Baby P."[3] In this, he appeared to echo the conclusions of many overviews of serious case reviews of child deaths which indicate there is rarely any single cause for these tragedies but an unanticipated and undetected combination of factors which creates the potential for catastrophe. Although action should be taken to improve and maintain standards of child protection practice wherever audits and reviews find them to be deficient, it is essential that managers and supervisors have sufficient time to devote to providing thorough, analytical, reflective and supportive supervision. In this way, an objective and professional oversight of complex and emotionally draining cases can assist is identifying and taking appropriate action when combinations of potentially dangerous circumstances occur.

[2] *The Protection of Children in England: A progress Report*, HMSO, March 2009

[3] Statement to Parliament, 12 March 2009

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We are grateful for the time and consideration given by managers and team leaders in completing this questionnaire. Although an additional burden to busy and demanding work schedules, the responses have been given obvious thought and demonstrate commitment to achieving high standards of professional practice.

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