CHILDREN'S SERVICES REVIEW COMMITTEE

9 April 2009

THE PROTECTION OF CHILDREN IN ENGLAND: A PROGRESS REPORT BY LORD LAMING

REPORT OF THE DIRECTOR OF CHILDREN'S SERVICES

Strategic Priority: Healthy City
Corporate Improvement Priority: Delivering Customer Focused Services, Improving Partnership Working to Deliver 'One City'

1. Why has this report come to the Committee?

1.1 This report and presentation from the Director of Children's Services, is being made to Committee to provide an update on the Lord Laming review, which is titled "Protection of Children in England: A Progress Report".

1.2 Review Committee are requested to note the content of this report and to support the proposals for taking forward the analysis and implementation of the Laming recommendations as they relate to services for children in Sunderland.

2. Background

2.1 Following the death of Baby P in Haringey in 2008, Lord Laming was asked by the Rt Hon Ed Balls, MP Secretary of State for Children, Schools and Families to prepare an independent report which assessed progress being made in the delivery of arrangements to protect children, and to identify any barriers to effective, consistent implementation and how these might be overcome.

2.2 Lord Laming's task was to evaluate the good practice developed since the publication of the report of his Independent Statutory Inquiry (2003)following the death of Victoria Climbié, to identify the barriers that are now preventing good practice becoming standard practice, and recommend actions to be taken to make systematic improvements in safeguarding children across the country.

2.3 The report, published on 12 March 2009, makes a total of 58 recommendations, divided under the following headings:

- Progress
- Leadership and accountability;
- Support for children;

- Inter-agency working;
- Children's workforce;
- Improvement and challenge;
- Organisation and finance; and
- Legal

2.4 The report also contains six priority actions for Government, Children's Trusts and their partners, Local Safeguarding Children Boards and Children's Social Care:

- The Secretaries of State for Health, Justice and Home Office, and Children, Schools and Families must collaborate in the setting of explicit strategic priorities for the protection of children and young people for each of the frontline services and ensure sufficient resources are in place to deliver these priorities.
- The Government must inject greater energy and drive into the implementation of change and support local improvement by establishing a powerful National Safeguarding Delivery Unit (NSDU), reporting directly to Cabinet.
- The Secretary of State for Children, Schools and Families must immediately address the inadequacy of the training and supply of frontline social workers. Lord Laming also welcomes the establishment of the Social Work Taskforce which we have invited to visit in Sunderland.
- The Secretary of State for Health must address the wariness of staff throughout the health service to engage with child protection work. GPs, community nurses and paediatricians must be helped to develop a wider range of skills and become very much more confident in this important area of work.
- The Home Secretary must address the adequacy of resources devoted to police child protection teams.
- The Secretary of State for Justice must take action to shorten the time taken in court process relating to the care of children.

2.5 The Laming Review is wide ranging and comprehensive and builds on the original Laming Review (2003), following the death of Victoria Climbié. (The 58 recommendations are attached at Appendix 1).

2.6 Speaking at the launch of the report, Lord Laming said, "Keeping children safe and promoting their welfare is a responsibility of us all, but more needs to be done to inject energy and drive into safeguarding and child protection across all frontline services."

"Throughout this task it has been clear that the vast majority of people working in this area aspire to improve the lives of the most vulnerable children and young people."

"I am convinced that with vision and ambition more can be done. That is why the recommendations I am making today herald the need for step change in expertise and leadership for frontline workers, backed

up with commitments from Government and other national bodies to drive this change forward."

2.7 There is an emphasis in the report on the important role of Government and to this effect, 44 of the recommendations are directed to Government departments. Fourteen recommendations are directed to local delivery bodies, such as Local Authorities, Children's Trusts and Local Safeguarding Boards.

3. Current position

3.1 In order to implement the Laming recommendations and thereby improve safeguarding outcomes for children, it is important that key agencies working with children give appropriate consideration to the report. The Council's Portfolio Holder for Children's Services has therefore written to all Sunderland Children's Trust members. The letter sets out three key proposals:

- that individual partners report to their respective executive bodies on the implications of the Laming report;
- that partners each develop a Laming action plan; and
- that the Children's Trust establishes a task and finish Laming Review action group to develop a Sunderland plan.

3.2 Work is already underway to ensure that the Children's Trust and Sunderland Safeguarding Children Board work effectively together to ensure that the maximum benefit for Sunderland's children, young people and their families is derived from the Laming recommendations.

4. Conclusion

4.1 This is a comprehensive review which seeks to tackle issues to improve safeguarding at both a national and local level. It also addresses the national challenges of the status of social work and the difficulty in recruitment and retention of experienced staff who want to work in child protection and safeguarding. The report also seeks to inject energy and dynamism into this work with Lord Laming's challenge of, "NOW JUST DO IT".

5 Recommendation

5.1 It is recommended that Children's Services Review Committee note the content of this report, and support the proposed actions in order that Children's Services has a strong and robust action plan to implement Lord Laming's recommendations.

5.2 It is recommended that Children's Services Review Committee agree to receive regular updates on the progress being made on the agreed actions.

6. Background Papers

6.1 The Victoria Climbié Inquiry, Report of an Inquiry by Lord Laming, 2003
Every Child Matters, DSCF, 2003
The Protection of Children in England: A Progress Report, The Lord Laming, 2009

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APPENDIX 1

THE PROTECTION OF CHILDREN IN ENGLAND: A PROGRESS REPORT

COMPLETE LIST OF RECOMMENDATIONS

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

	RECOMMENDATION
	Leadership and Accountability
3.	The Cabinet Sub-Committee on Families, Children and Young People should ensure that all government departments that impact on the safety of children take action to create a comprehensive approach to children through national strategies, the organisation of their central services, and the models they promote for the delivery of local services. This work should focus initially on changes to improve the child-focus of services delivered by the Department of Health, Ministry of Justice and Home Office.
4.	The Government should introduce new statutory targets for safeguarding and child protection alongside the existing statutory attainment and early years targets as quickly as possible. The National Indicator Set should be revised with new national indicators for safeguarding and child protection developed for inclusion in Local Area Agreements for the next Comprehensive Spending Review.
5.	The Department of Health must clarify and strengthen the responsibilities of Strategic Health Authorities for the performance management of Primary Care Trusts on safeguarding and child protection. Formalised and explicit performance indicators should be introduced for Primary Care Trusts.
6.	Directors of Children's Services, Chief Executives of Primary Care Trusts, Police Area Commanders and other senior service managers must regularly review all points of referral where concerns about a child's safety are received to ensure they are sound in terms of the quality of risk assessments, decision making, onward referrals and multi-agency working.
7.	All Directors of Children's Services who do not have direct experience or background in safeguarding and child protection must appoint a senior manager within their team with the necessary skills and experience.
8.	The Department for Children, Schools and Families (DCSF) should organise regular training on safeguarding and child protection, and on effective leadership for all senior political leaders and managers across frontline services.
9.	Every Child's Trust should ensure that the needs assessment that in forms their Children and Young People's Plan regularly reviews the needs of all children and young people in their area, paying particular attention to the general need of children and those in need of protection. The National Safeguarding Delivery Unit should support Children's Trusts with this work. Government Offices should specifically monitor and challenge Children's Trusts on the quality of this analysis.

	RECOMMENDATION
	Support for children
10.	Ofsted should revise the inspection and improvement regime for schools giving greater prominence to how well schools are fulfilling their responsibilities for child protection.
11.	The DCSF should revise *Working Together to Safeguarding Children* to set out clear expectations at all points where concerns about a child's safety are received, ensuring intake/duty teams have sufficient training and expertise to take referrals and that staff have immediate, on-site support available from an experienced social worker. Local authorities should take appropriate action to implement these changes.
12.	The DoH and DCSF must strengthen current guidance and put in place the systems and training so that staff in Accident and Emergency departments are able to tell if a child has recently presented at any A&E and if a child is the subject of a Child Protection Plan. If there is any cause for concern, staff must act accordingly, contacting other professionals, conducting further medical examinations of the child as appropriate and necessary, and ensuring no child is discharged whilst concerns for their safety or well-being remain.
13.	Children's Trusts must ensure that all assessments of need for children and their families include evidence from all the professionals involved in their lives, take account of case histories and significant events (including previous assessments) and above all must include direct contact with the child.
14.	Local authorities must ensure that 'Children in Need', as defined by Section 17 of the Children Act 1989, have early access to effective specialist services and support to meet their needs.
15.	The Social Work Taskforce should establish guidelines on guaranteed supervision time for social workers that may vary depending on experience.
16.	The DCSF should revise *Working Together to Safeguard Children* to set out the elements of high quality supervision focused on case planning, constructive challenge and professional development.
17.	The DCSF should undertake a feasibility study with a view to rolling out a single national Integrated Children's System better able to address the concerns identified in this report, or find alternative ways to assert stronger leadership over local systems and their providers. This study should be completed within six months of this report.
18.	Whether or not a national system is introduced, the DCSF should take steps to improve the utility of the Integrated Children's System, in consultation with social workers and their managers, to be effective in

	RECOMMENDATION
	supporting them in their role and their contact with children and families, partners, services, and courts, and to ensure appropriate transfer of essential information across organisational boundaries.
	Interagency Working
19.	The DCSF must strengthen *Working Together to Safeguarding Children,* and Children's Trusts must take appropriate action to ensure: • all referrals to children's services from other professionals lead to an initial assessment, including direct involvement with the child or young person and their family, and the direct engagement with, and feedback to, the referring professional; • core group meetings, reviews and casework decisions include all the professionals involved with the child, particularly police, health, youth services and education colleagues. Records must be kept which must include the written views of those who cannot make such meetings; and • formal procedures are in place for managing a conflict of opinions between professionals from different services over the safety of a child.
20.	All police, probation, adult mental health and adult drug and alcohol services should have well understood referral processes which prioritise the protection and well-being of children. These should include automatic referral where domestic violence or drug or alcohol abuse may put a child at risk of abuse or neglect.
21.	The National Safeguarding Delivery Unit should urgently develop guidance on referral and assessment systems for children affected by domestic violence, adult mental health problems, and drug and alcohol misuse using current best practice. This should be shared with local authorities, health and police with an expectation that the assessment of risk and level of support given to such children will improve quickly and significantly in every Children's Trust.
22.	The DCSF should establish statutory representation on Local Safeguarding Children Boards from schools, adult mental health and adult drug and alcohol services.
23.	Every Children's Trust should assure themselves that partners consistently apply the Information Sharing Guidance published by the DCSF for Communities and Local Government to protect children.
	Children's Workforce
24.	The Social Work Taskforce should: • develop the basis for a national children's social worker supply strategy that will address recruitment and retention difficulties, to be

	RECOMMENDATION
	implemented by the DCSF. This should have a particular emphasis on child protection social workers; • work with the Children's Workforce Development Council and other partners to implement, on a national basis, clear progression routes for children's social workers; • develop national guidelines setting out maximum case-loads of children in need and child protection cases, supported by a weighting mechanism to reflect the complexity of cases, that will help plan the workloads of children's social workers; and • develop a strategy for remodelling children's social work which delivers shared ownership of cases, administrative support and multi-disciplinary support to be delivered nationally.
25.	Children's Trust should ensure a named, and preferably co-located, representative from the police service, community paediatric specialist and health visitor are active partners within each children's social work department.
26.	The General Social Care Council, together with relevant government departments, should: • work with higher education institutions and employers to raise the quality of consistency of social work degrees and strengthen their curriculums to provide high quality practical skills in children's social work; • work with higher education institutions to reform the current degree programme towards a system which allows for specialism in children's social work, including statutory children's social work placements, after the first year; and • put in place a comprehensive inspection regime to raise the quality and consistency of social work degrees across higher education institutions.
27.	The DCSF and the Department for Innovation, Universities and Skills should introduce a fully-funded, practice-focused children's social work post graduate qualification for experienced children's social workers, with an expectation they will complete the programme as soon as is practicable.
28.	The DCSF, working with the Children's Workforce Development Council, General Social Care Council and partners should introduce a conversion qualification and English language test for internationally qualified children's social workers that ensure understanding of legislation, guidance and practice in England. Consideration should be given to the appropriate length of a compulsory induction period in a practice setting prior to formal registration as a social worker in England.
29.	Children's Trusts should ensure that all staff who work with children receive initial training and continuing professional development which

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

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

	RECOMMENDATION
46.	Government Offices must ensure that there are enough trained Serious Case Review panel chairs and authors available within their region.
47.	Ofsted should share full Serious Case Review report with HMI Constabulary, the Care Quality Commission, and HMI Probation (as appropriate) to enable all four inspectorates to assess the implementation of action plans when conducting frontline inspections.
48.	Ofsted should share Serious Case Review executive summaries with the Association of Chief Police Officers, Primary Care Trusts and Strategic Health Authorities to promote learning.
49.	Ofsted should produce more regular reports, at six monthly intervals, which summarises the lessons from Serious Case Reviews.
	Organisation and Finance
50.	The DCSF must provide further guidance to Local Safeguarding Children Boards on how to operate as effectively as possible following the publication of the Loughborough University research on Local Safeguarding Children Boards later this year.
51.	The Children's Trust and the Local Safeguarding Children Board should not be chaired by the same person. The Local Safeguarding Children Board should be selected with the agreement of a group of multi-agency partners and should have access to training to support them in their role.
52.	Local Safeguarding Children Boards should include membership from the senior decision makers from all safeguarding partners, who should attend regularly and be fully involved as equal partners in Local Safeguarding Children Board decision making.
53.	Local Safeguarding Children Boards should report to the Children's Trust Board and publish and annual report on the effectiveness of safeguarding in the local area. Local Safeguarding Children Boards should provide robust challenge to the work of the Children's Trust and its partners in order to ensure that the right systems and quality of services and practice are in place so that children are properly safeguarded.
54.	The DCSF, the DoH, and the Home Office, together with HM Treasury, must ensure children's services, police and health services have protected budgets for the staffing and training for child protection services.
55.	The DCSF must sufficiently resource children's services to ensure that early intervention and preventative services have capacity to respond to all children and families identified as vulnerable or 'in need'.

	RECOMMENDATION
56.	A national annual report should be published reviewing safeguarding and child protection spend, against assessed needs of children across the partners in each Children's Trust.
	Legal
51.	The Ministry of Justice should lead on the establishment of a system-wide target that lays responsibility on all participants in the care proceedings system to reduce damaging delays in the time it takes to progress care cases where these delays are not in the interests of the child.
58.	The Ministry of Justice should appoint an independent person to undertake a review of the impact of court fees in the coming months. In the absence of incontrovertible evidence that the fees had not acted as a deterrent, they should then be abolished from 2010/11 onwards.