

**C4EO**  
**EXCELLENCE AND EVIDENCE – MAKING THE**  
**DIFFERENCE CONFERENCE**  
**London 29<sup>th</sup> June 2010**

**Safeguarding**

Jacky Tiotto, Department for Education

**I want children to smile.  
If they are smiling they will be relaxed.  
If they are relaxed, they will be confident.  
If they are confident, they will dare to be curious.  
If they are curious, they will grow in understanding.**

**Anne Wood  
Ragdoll productions**

Munro review of child protection

Serious Case Reviews

Messages from existing knowledge

Cost effectiveness programme

Celebration of impact and 'difference making'

# Context...

- New coalition Government
- Economic climate
- Heightened awareness of vulnerable children → increased demand:
  - Referrals ↑ 2%
  - initial assessments ↑ 9%
  - core assessments ↑ 15%.
  - Care Demand 2009-10 ↑ 34% compared to 2008-2009 (CAFCASS).
  - children with child protection plans ↑ 11%
- Higher expectations of services, more authorities in intervention
- **Early intervention – the challenge and the solution**

# Munro Review of child protection

- 10<sup>th</sup> June, Government announced the independent review
- Child Protection system not working as well as it should
- Review wide ranging and broad in scope
- Explicitly centred around the things that help professionals make the best judgement they can to protect a vulnerable child
- Social Work profession needs strengthening in order to make those best judgements
- Confident, responsible and accountable – but free from blame
- Where bureaucracy gets in the way, there needs to be less
- Includes effectiveness of other agencies in supporting social workers

*‘what helps professionals make the best judgements they can to protect a vulnerable child?’*

“ Child protection workers have to make complex judgements and difficult decisions in conditions of limited knowledge, time pressures, high emotions and conflicting values”

Eileen Munro – Effective Child Protection- 2<sup>nd</sup> edition 2008

## Call for Evidence: 1 July – 30<sup>th</sup> July 2010

- Solutions, Best Practice and Innovation – new lines of enquiry
- Building on what we know already and the evidence we have
- Building on work of the Social Work Taskforce and Lord Laming's progress report
- Cost Effective innovative practice that improves child protection
- Learning from practice central

# Call for Evidence: 1 July – 30<sup>th</sup> July 2010

## Early Intervention

- ✓ *Identifying and helping children and young people in need*

## Professional Practice

- ✓ *Evidence of improved social work practice in assessing and helping families and the extent to which this is possible due to professional freedom and time with families*
- ✓ *Strategies for helping social workers pursue difficult issues with families whose needs may be complex and/or where families are reluctant to engage*
- ✓ *Approaches to case discussions or other strategies which evidence the quality of front-line practice*

## Transparency and Accountability

- ✓ *Strategies for shared learning from practice experience including critical incidents and serious case reviews that recognise accountability but counteract any tendency towards a blame culture*
- ✓ *Local solutions that have been developed to help social workers be clearer about their responsibilities and which make practice more transparent*

# What is in scope?

## EARLY INTERVENTION

*Thresholds,  
Early Support and  
Universal  
Services*

*Cost Effectiveness  
New models of  
Social Work  
Delivery*

## FRONTLINE SOCIAL WORK PRACTICE

*Professional Freedom,  
Supervision and  
Bureaucracy*

*Performance  
Frameworks  
Targets / Use of Data*

*Recording and ICT*

*Improvement support*

## TRANSPARENCY AND ACCOUNTABILITY

*SCR Policy /  
Models of learning*

*Risk and Blame*

*Inspection and  
Accountability*

# Timescales

Evidence report end  
of September 2010



Interim report in  
January 2011



Final report in April  
2011

# Serious Case Reviews

- Policy position requiring all new Serious Case Reviews initiated from 10 June 2010 to be published by LSCBs UNLESS compelling reasons not to, which relate to the welfare of a child/ren concerned.
- SCR executive summaries and overview reports with identifying details removed before publication
- For lessons to be learned, professionals need to understand fully what happened and what needs to change to reduce risk of it happening again
- Aim also to restore public confidence and improve transparency in child protection system
- Balance between transparency, openness and protection of vulnerable children and their families
- Social Workers historically getting blame, publishing will make it clear that other professionals are involved

## 2003-5

- 161 children died or seriously injured, **47% under 1 yr**
- 66% of children died, 34% of children were seriously injured
- Older children judged 'hard to help'
- **12% on CPR and 55% known to children's social care**
- Younger children in universal services not children's social care
- **Repeated 'start again syndrome'**
- Over 50% living at home with domestic violence and often additionally a parent with mental ill health and/or substance misusing
- **Thresholds and eligibility criteria central concern over child welfare**

## 2005-7

- 179 children died or seriously injured, 70% under 5yrs, **46% under 1 yr**
- **17% of children on CPR** , 78% of all 179 children were living at home
- ***Those seriously injured children had long histories of neglect and concern, the effects of which could have been minimised if agencies had worked together earlier and worked effectively***
- overwhelmed families, **children invisible to professionals**
- **rehearsal' incident prior to death or serious injury**
- **high risk environment for the child (drugs, domestic violence)**
- **silos practice**, poor inter-agency working, low levels of challenge in long term work
- fixed thinking about the family and low expectations from professionals
- **repeated 'start again syndrome'**

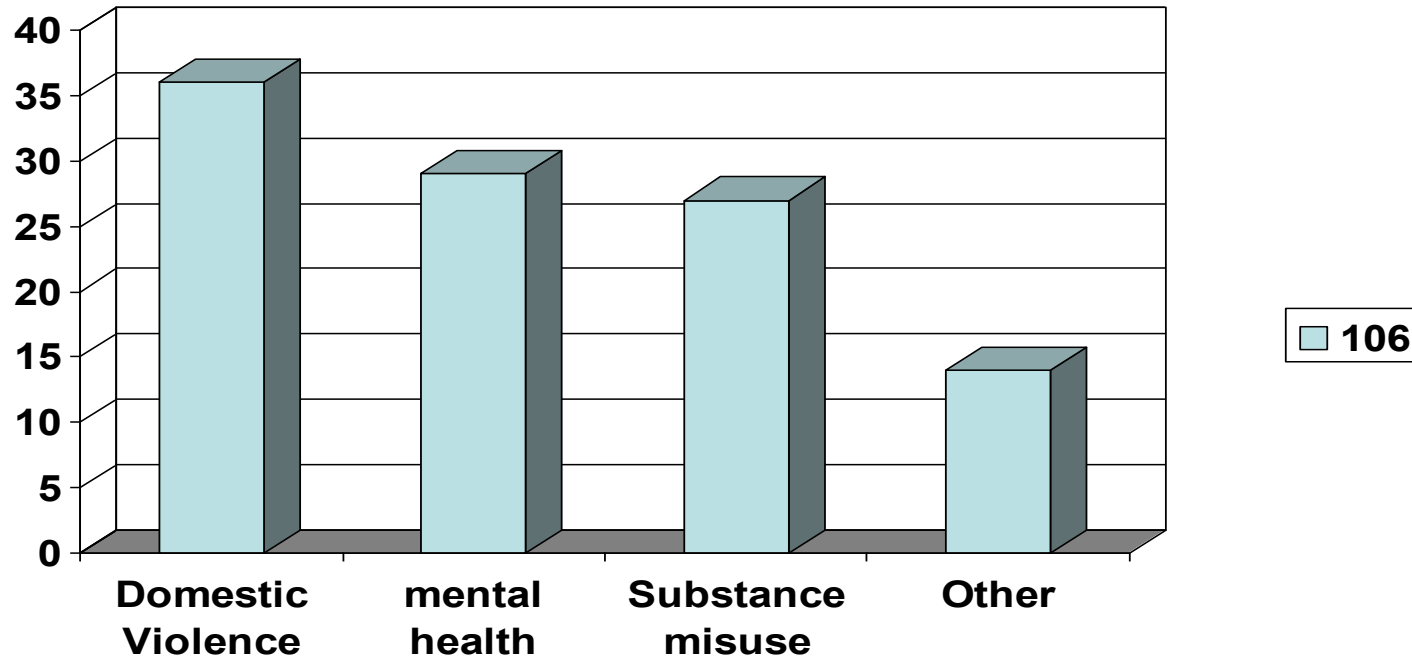
# Ofsted: Learning lessons from serious case reviews: interim reports for 2009 and 2010 Key findings

- <5 yr olds most at risk
- Physical abuse most common characteristic of the incidents reviewed.
- Minority of children, 41 / 106 in contact with social care services at time of the incident.
- Lack of complete picture of the child's family and a full record of the concerns. Holistic assessments of risk were not made routinely. Universal services focused on presenting issues.
- Lack of focus on child over family
- Examples of poor communication and information sharing between agencies
- Inadequate management oversight, clinical challenge and decision-making

# Chronologies, whole story and What is it like to be me?

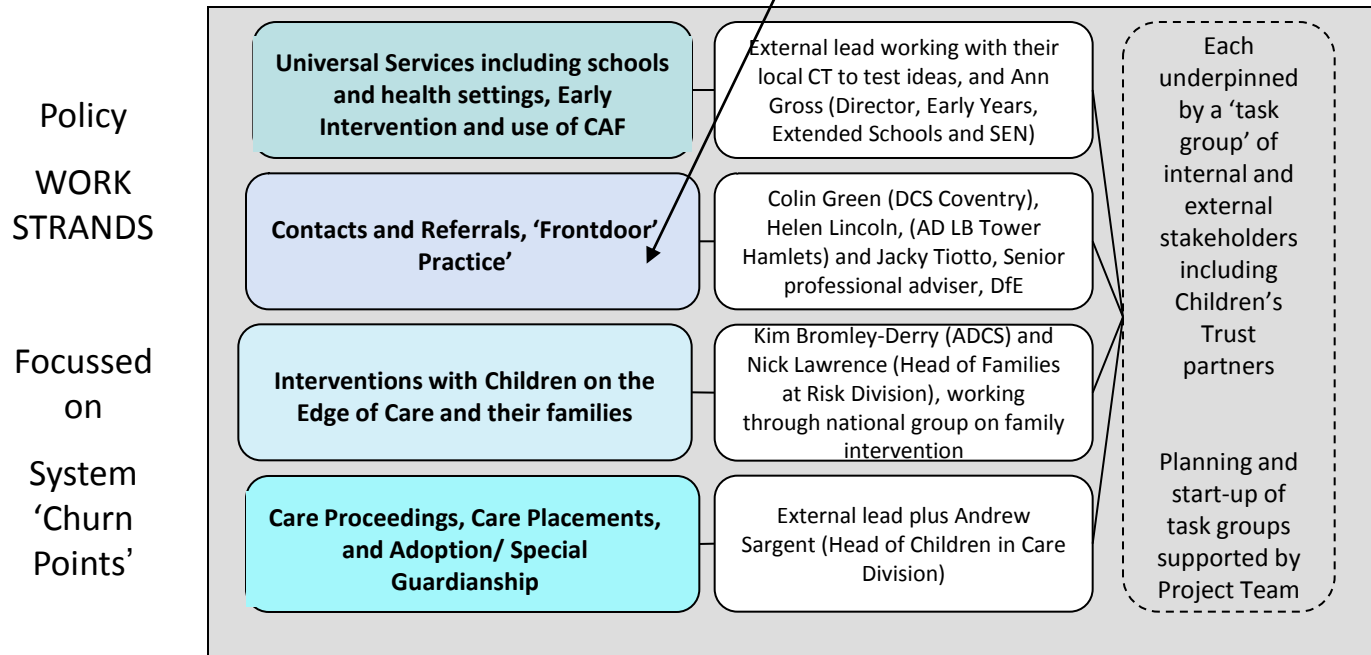
## Family Characteristics: Ofsted 2010

The incidence of these factors was more frequent in cases where children had died than in non-fatal cases.



# Programme Structure - Cost Effectiveness of Children's Services

There are four strands to the cost effectiveness work. Discussion focussed on Contacts and Referrals: 'Front Door Practice'



# Do the right children and young people get the right intervention when they need it?

Are the right children and young people progressing through the system of assessment?

What services should be available at the point of first referral?

Does this assessment always involve direct contact with those children and young people?

How can increased demand at the 'frontdoor' be managed safely?

Is more possible with less resource overall?

# Demand for children's social care is rising

- **referrals:** ↑ 16.5%
- **section 47 enquiries:** ↑ 21.3%
- **initial Assessments:** ↑ 23.4% (10 LAs - increase of >100%)
- **children subject of Initial Child Protection Conference:** ↑ 20%
- **children subject of Child Protection Plan:** ↑ 32.9% (28 LAs - increase of >50%)
- **children starting to be looked after:** ↑ 17.2% (19 LAs – increase >50%)
- **children looked after at end of period:** ↑ 8.1%
- **staffing levels:** 10.5% of manager, deputy manager and social worker posts were covered by agency staff and 12.5% of posts vacant (Dec 09)

## Points to note

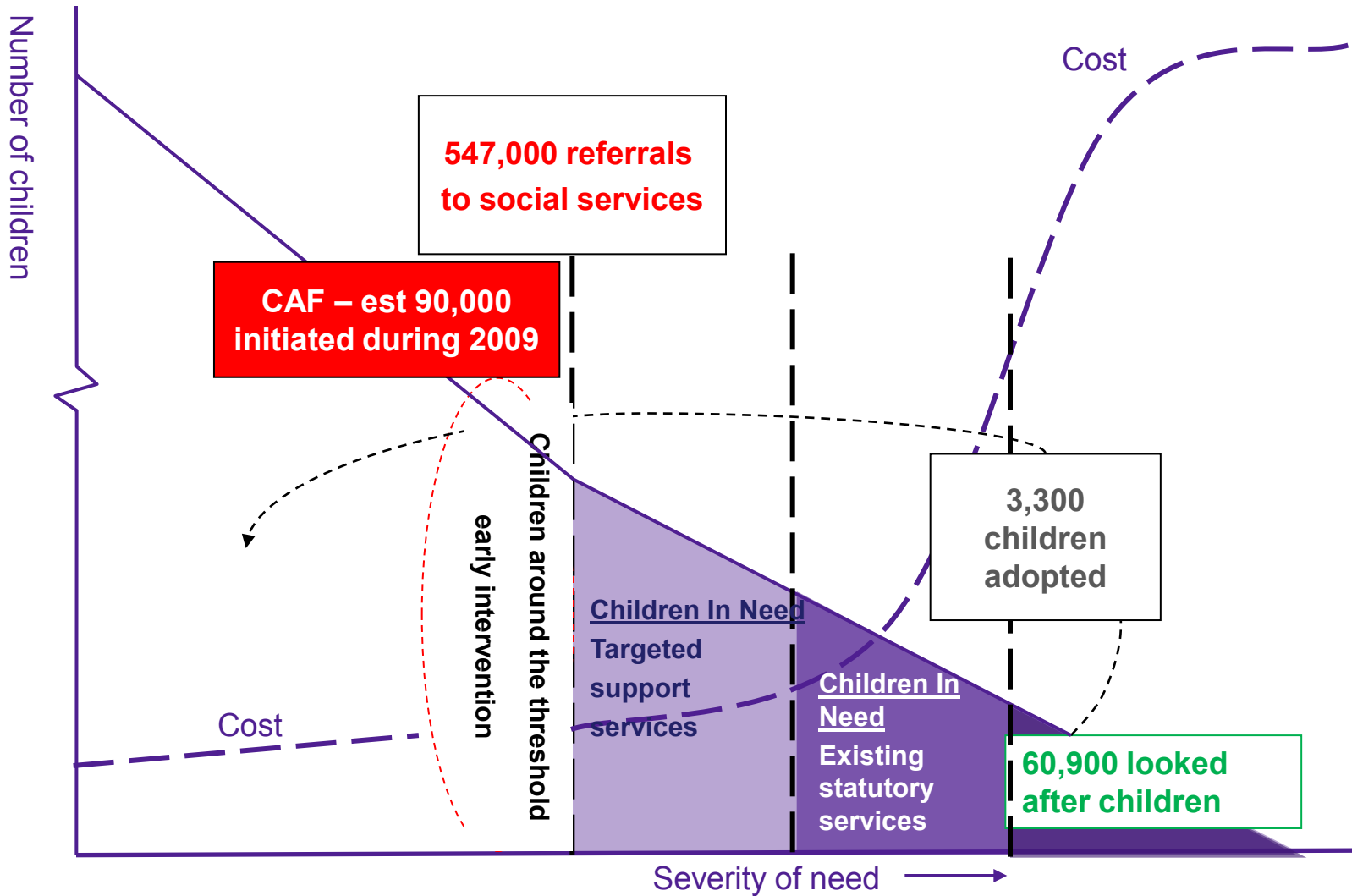
- 80% of those originally referred are not proceeding beyond initial assessment
- SCRs, child protection plans or applications for care (later) identify for many CYP at this stage that there needed to be a substantial offer of intervention
- Often there are child protection risks in the space of contact and referral – where families are below a threshold but there are dangers, ie from alcohol, drugs, violence, mental ill health or something else

- We are trying to look at ways of managing better at this point for two reasons

*(i) to prevent onward progression through the system where an earlier intervention could help*

*(ii) to ensure that children are not left out of the system and at risk when they should be receiving a more formal social work or family support offer*

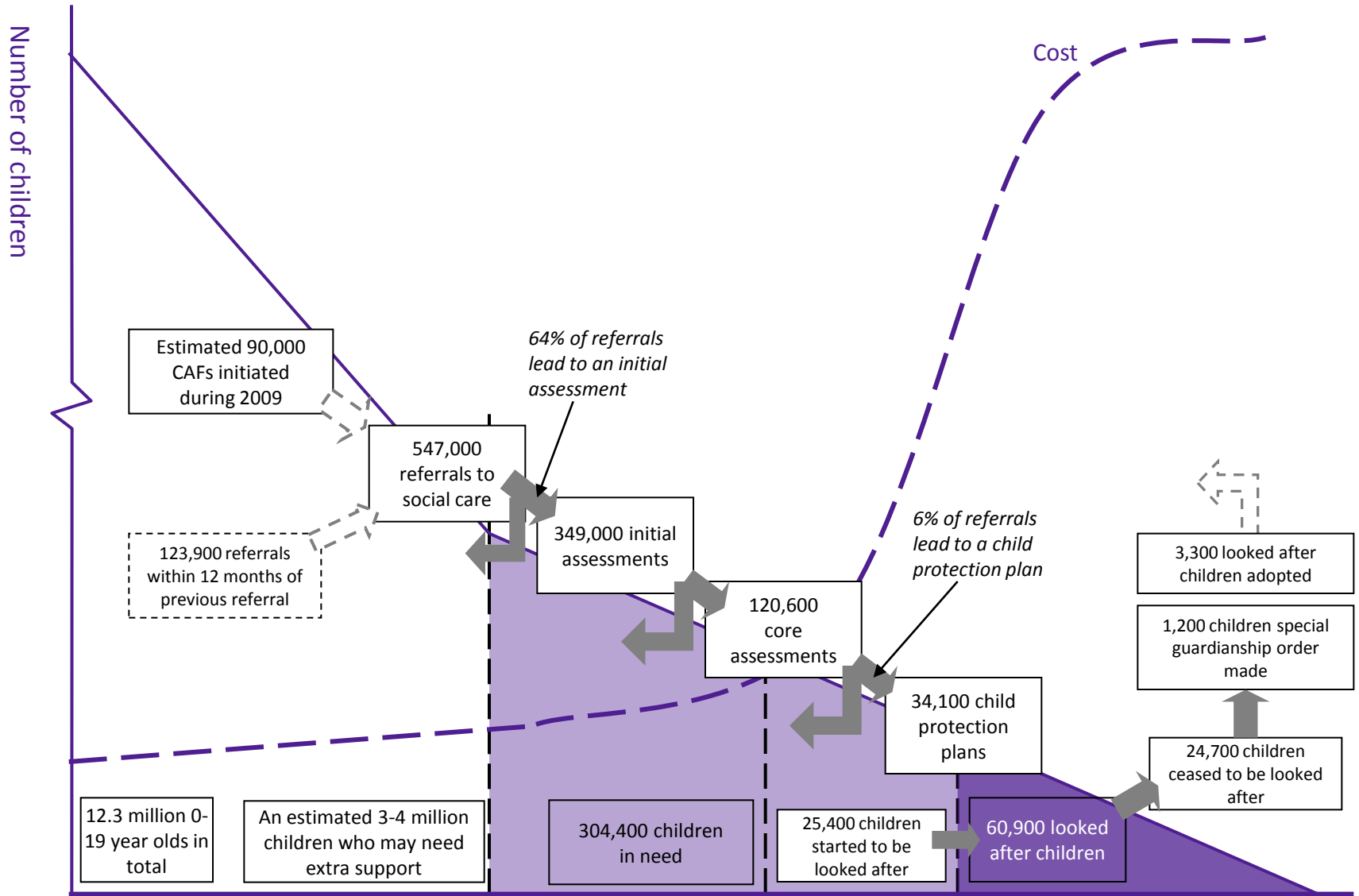
# What happens when children are referred?



- Is the threshold for assessment right, given that 80% of referrals do not proceed to a core assessment?
- What services are provided to children in need (those children assessed as needing support other than child protection?)
- What is happening to the children who ‘fall out’ at each stage of assessment?

\*Progress will not always be linear

# Numbers of children



# Questions that remain...

Should children's centres prioritise vulnerable children or those in need in accordance with Section 17?

Does future policy involve a fuller role for schools in early intervention, with support from multi-agency teams?

Who will take this work forward with professional bodies and others to better understand how to support the workforce in taking on any new roles?

How should we examine the application of section 17 and child protection thresholds in local services?

# Questions that remain...

Should universal services, supervised by social workers, bear the level of risk associated with working with families where there is domestic violence, mental ill health and/or substance misuse issues?

There may be some limited additional costs re earlier support to manage risk & vulnerability within universal services. Who should bear this cost?

Should the scope of any safeguarding review explore the issue of the effectiveness of existing statutory interventions, including assessment and other administrative processes?

# Finally

- Most children, young people and families are known to a range of agencies
- We all have shared accountability for protection of children
- We can do this by providing effective services for the most vulnerable as early as possible; recognising & addressing risk factors, sharing information and working together

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