Wigan Council

This is an Open Report

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Report to:	**Overview and Scrutiny Committee**
Date:	**22 April 2009**
Subject:	**Social Care Audit and Action Plan**
Report of:	**Executive Director of Children and Young People's Services**
Contact officer:	**Marlyn Banham 01942 486003; m.banham@wigan.gov.uk**

Purpose / summary:

- To inform members of the outcome of an audit into Social Care provision in relation to safeguarding.
- To outline proposals for change in response to this audit and the Laming Report issued in March 2009.

Alternative options considered and reason for selecting the one recommended:

No options have been considered.

Recommendation / decision:

Members are asked:

- To receive the detailed report of the audit into safeguarding activity within Social Care.
- To note the recommendations of Lord Laming's report "The Protection of Children in England".
- To accept the recommendations outlined under Section 6 Key Issues for change.

The decision will be made as a result of this report and will be published within 48 hours

Risks / Implications:

Financial:	There are financial implications attached to this report.
Staffing:	There are staffing implications to this report.

Policy:	Policy implications are addressed within this report.
Equal Opportunities – Has a Diversity Impact Assessment been conducted?	No
Wards affected:	all

Property Implications – Does the proposal involve a reduction, addition or change to the Council's asset base or its occupation?
No
If yes, have the property implications been agreed with the Corporate Property Officer?

Does this proposal have significant implications for the Council and the local population?
A diversity impact assessment is not necessary at this stage, however, equality and diversity implications have been considered when producing this report.
Does this proposal involve a new policy or procedure or significant changes to an existing policy or procedure?
A diversity impact assessment is not necessary at this stage, however, equality and diversity implications have been considered when producing this report.

Has the Service Director – Borough Solicitor confirmed that the recommendations within this report are lawful and comply with the Council's Constitution?	**Yes / No** *
Has the Service Director – Corporate Services confirmed that any expenditure referred to within this report is consistent with the Council's budget?	**Yes / No** *
Are any of the recommendations within this report contrary to the Policy Framework of the Council?	**Yes / No** *

* delete which applicable

For Cabinet reports only :

Categorisation of the report:	x
Discussion leading to a decision	
Monitoring	
Sharing for corporate understanding	

	x
Discussion	
Decision	
Information	

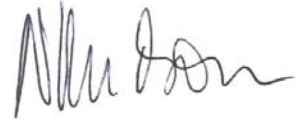
Tracking/Process:

	Consultation	Ward Members	Partners
Panel	Overview & Scrutiny	Cabinet	Council

	6th April 2009		

There are no Background Papers to this Report within the meaning of Section 100D of the Local Government Act 1972.

Proper Officer



Date 26th March 2009

Diversity Impact Assessment form

Section:

Policy/Service Area:

Person Completing Form:	Date:

Do any of the below groups suffer specific disadvantage (please indicate)

	Yes	No		Yes	No
Race			Disability		
Ethnicity			Gender		
Age			Religion		
Class			Sexual Orientation		

Is there evidence of disadvantage or associated problems?

How was the information collected and/or who have you consulted with?

Action Plan – *What specific actions are planned to tackle any disadvantage identified?*

Is the policy in line with current equality legislation and relevant codes of practice?

Timescale	
Responsibility	
Comments	

Are the actions specified included in any other documents/plans?

Departmental Service Plan	
Section/Team Plan	
Other (Specify)	

Date for further review

1. Background

1.1 In January 2009 Members received a briefing paper outlining proposals to undertake an audit of social care functions in relation to safeguarding. This was as a consequence of the Haringey JAR following the death of baby P. which highlighted a series of weaknesses in Haringey's child protection arrangements.

1.2 A detailed audit and action plan was presented to Members outlining the action being taken by Social care services in Wigan to ensure that appropriate action was being taken to address all the areas of concern highlighted in:

- The recommendations from the Laming Inquiry in the death of Victoria Climbie (2003)
- The recommendations from the serious case review in Wigan (2008) and the action plan of the Wigan Safeguarding Children Board (WSCB) which followed
- The recommendations from the Haringey Joint Area Review

1.3 This audit was completed in Mid March and coincided with the publication of the review ordered by the government from Lord Laming. The Protection of Children in England: A Progress Report

1.4 The Wigan Safeguarding Children Board invited other departments of the council and partner agencies to submit any action plans they may be required to develop to the Executive to ensure that the Board can work to one agreed plan, monitored via the Executive and reporting to the Board as necessary.

1.5 A training programme was to be developed to address Member's responsibilities in regard to child protection / safeguarding issues.

1.6 Cabinet requested a detailed report on the outcome of the social care audit

2. Progress of the Audit

2.1 The social care action plan concentrated on three key objectives:-

- Review the policies and procedures underpinning child protection
- Provide targeted training in key areas of child protection
- Review capacity and workload management

2.2 Objective 1: Review policies and procedures underpinning child protection

2.2.1 This objective was divided in to three main tasks:

- update current guidance;
- develop new guidance,
- ensure procedures are accessible on the Wigan Intranet.

The planned outcome is to enable all social care workers to have access to up to date guidance to support good practice.

Findings

2.2.2 Most of the core procedures for social care workers in relation to children in need and child protection have been written and are in the process of being inputted onto the intranet. Practice has been reviewed and guidance updated for seven out of the nine areas originally identified for the audit.

2.2.3 Eight areas were identified where new practice guidance was needed and some of these are key issues and recurring themes to be discussed later in this report. These relate to supervision, recording and file management, managing cases where domestic violence and non engagement is an issue and cases awaiting allocation.

2.2.4 Policies and procedures need to be an up to date, accessible working tool for practitioners. The route to find the social care procedures on the intranet is currently complicated and needs to be simplified. Challenges already exist in ensuring that the procedures are compatible with the extensive changes to policy and guidance issued by Government therefore a review of the structure and management of the system is needed. Benchmarking good practice from other Local Authorities is also needed in this area.

2.2.5 At present the service has a particular challenge in responding to the requirements for the Integrated Children's System (ICS), a complex and time consuming set of recording requirements.

Integrated Children's System

2.2.6 ICS is a Government requirement to electronically record a child's record to ensure consistency in assessment, recording, review and planning. It has the potential to aid performance monitoring as case information can easily be accessed by others.

2.2.7 The overall experience of social workers and managers in using ICS on a daily basis is that it is rigid, cumbersome, frustrating and inflexible. It does not promote creative and reflective, analytical thinking.

2.2.8 Recording practice and chronologies are key areas of practice that have been identified as problematic in Haringey and Wigan.

2.2.9 Chronologies are key to effective assessments and the importance of understanding current circumstances within the context of the family's previous history.

2.2.10 ICS has a complex system of chronologies however they cannot easily produce a single, user-friendly document to share with other professionals or the family and cannot easily be accessed to identify patterns or concerns within a family.

2.2.11 It may be that the system will be modified and improved as new versions of ICS are developed.

2.2.12 Check list guides for ICS have been developed but have not yet been implemented due to competing demands and capacity in the service to implement a major change programme not just in recording but in relation to how practice is undertaken.

Recommendations:

2.2.13 Writing, updating and disseminating policies, procedures and practice guidance for Social Care is an ongoing task which must be underpinned by access to current national and local research, guidance and legislation. This could be most effectively achieved through a dedicated development post.

2.2.14 Chronologies are a key tool for practitioners. It is recommended that paper chronologies are maintained in addition to the ICS format until the ICS versions are user-friendly.

2.2.15 The impact on social workers' and Team Manager's time needs to be recognised while the system is relatively new and not fully implemented. Training on each part of the system as it develops detracts from time for casework and the inputting of data by practitioners is slow at each new stage until they develop competence.

2.2.16 It is imperative that sufficient resource is provided to the ICS team to implement the process writing, testing, training, and floor walking necessary to implement the child protection and subsequent phases and reduce duplication for social workers.

2.3 Objective 2: To provide targeted training in the key areas of child protection

2.3.1 Five key areas were identified and have been addressed, along with an audit of the child protection training completed by social workers in the Duty and Children in Need teams.

The planned outcomes are:

- that all social care staff working at thresholds 3b and 4 will receive formal training to improve the effectiveness of their practice and ensure staff always use evidence based interventions

- that the wishes and feelings of the child will be effectively sought and clearly recorded in every report about them
- that there will be improved recording practice and decision making
- that the quality of supervision will improve and staff will feel supported
- that there will be clearer monitoring of child protection plans within core groups

Summary of findings:

Positives:

2.3.2 An intensive, two-day training course was commissioned on the key area of analysis of information and risk. It was well attended by 20 social workers including newly qualified workers and three Team Managers.

2.3.3 Two linked courses have been commissioned on supervision and these were held at the end of March 2009. One is a new course aimed at supervisees, to enable them to get the most out of their supervision experience.
The other is for managers and supervisors to focus on the need to address all aspects of supervision including performance management as well as practice and staff support.

2.3.4 Joint training has been commissioned from an independent training consultant for Team Managers and Independent Reviewing Officers which focuses on improving assessments by using specialist tools.

2.3.5 Training on core groups was identified from a recent Serious Case Review and is due to take place for Social Workers in April 2009. The aim is for the training to become part of the core multi-agency Safeguarding training programme.

2.3.6 Accessing the voice of the child is central to all assessments. Many of the social care staff in the Children in Need teams have already received intensive training on developing communication skills with children and young people. The views of young people from the Youth Council have been shared with Social Workers.

2.3.7 Training has been identified on computer-assisted communication with young children and disabled young people. There are some very good examples in assessments and court reports of the child’s views being presented.

2.3.8 A briefing session was offered to the Newly Qualified Social Work group (NQSW) on undertaking Section 47 investigations. The session was well attended and will be presented again in May 2009.

2.3.9 Initial training has been provided on the Graded Care Profile in order to pilot the use of this tool to measure neglect. The areas of Tyldesley, Atherton and Astley have been identified as the pilot area for this multi-agency approach.

2.3.10 The core and specialist child protection training undertaken by social care

staff in the Duty and Children in Need teams has been collated and recorded. A tool has been developed to allow Team Managers to identify who in their team has particular interests and skills and where there are training needs. The record can be regularly updated.

Concerns:

2.3.11 Two key issues recognised within the training on Analysis were:

- The need for uninterrupted time for social workers to consider the information and evidence they have collated in order to fully understand and analyse its significance.
- The importance of support, guidance and advice from experienced and competent supervisors and managers to assist with this process.

2.3.12 The training programme made available during the period of the audit has been intense. It has required both social workers and managers to spend time away from casework which impacts on their workload on their return. It has required senior managers to provide supervisory cover during absences which has similarly impacted on their other work. The effect can be to increase the pressure staff feel about their workload.

Outstanding tasks/Recommendations

2.3.13 The following areas remain outstanding and will require attention.

- Social care staff who have been employed since the training on direct work was offered would benefit from being able to access this, as would staff from the Duty/Duty Support team and other teams
- Addressing the communication needs of young children and disabled children and young people is essential. Access to specialist training in this area should be promoted and supported with the appropriate tools.
- The training provided on Analysis would be advantageous not only to other social workers but also to a wider range of staff.

  The pilot implementation of the Graded Care Profile begins to address the identified need for formal tools to improve assessments.
- Information packs for children coming into care were developed some time ago and would benefit from review.

2.4 Objective 3: To review capacity and workload management

2.4.1 This objective focused on 3 areas

- staff views;
- social workers' and managers' capacity
- developing support systems.

2.4.2 The planned outcomes are:

- that all social care staff working at thresholds 3b and 4 will have a managed workload which enables them to work with all children, young people and families effectively.
- that social work time will be released for child/family activities.
- that evidence will be provided to inform service delivery

Findings:

Positives:

2.4.3 The audit provided the opportunity to speak directly with a wide range of staff within the Children in Need part of the service. The overwhelming impression is of a really committed, supportive and exceptionally hard-working group of people who want to do their job well.

2.4.4 Staff have been given a range of opportunities to contribute their views and concerns to the audit. They have welcomed this and contributed well. It has been positive that no really serious issues have been raised about current practice in Wigan.

2.4.5 In order to support social workers with their workload, a new administrative support service has been piloted as part of the Action Plan.

2.4.6 The initial review of this is recorded elsewhere but the overriding response from social workers has been extremely positive.

2.4.7 They have been able to delegate more of the administrative parts of their job enabling them to complete specialist social work tasks. It is a service which Social Workers say they would value and we would wish to see extended.

2.4.8 No structured scheme has been used in recent years within the Children in Need service in Wigan to measure and manage social workers' workload. This has been raised by Lord Laming and it is expected national guidelines will follow.

2.4.9 The three Children in Need teams work very well together. There is a strong sense of identity and mutual support amongst the staff teams and the managers which promotes good practice, motivation, resilience and loyalty.

2.2.10 Agency staff are employed and well-integrated; a number of them have stayed for considerable periods (over a year). The teams have benefited from additional resources to employ temporary support workers. All these factors have contributed to retaining social workers in these three teams.

2.2.11 A new, intensive process for interviewing social work staff has been piloted then implemented over the last year with the aim of improving the calibre of social workers appointed in the Children in Need and Duty teams.

2.2.12 Wigan Social Care is part of the Newly Qualified Social Workers' pilot scheme (NQSW). This has been implemented during the period of the audit.

2.2.13 Whilst further work is required to measure its effectiveness, the aim is to provide newly qualified social workers with additional support and training during their first year of practice. It is the first time that this has been offered in a formal way and assists Team Managers and Senior Social Workers with the tasks of induction and mentoring.

Concerns

2.2.14 The most vulnerable area identified within Wigan's child protection system relates to capacity.

2.2.15 As strong as the impression of a workforce committed to doing an effective job, was the impression that they are continuously frustrated by the pressure of the huge amount of complex work they are expected to achieve.

2.2.16 This results in reported high levels of stress amongst Social Workers and managers in response to the competing pressures of the work and concerns that all children do not receive an effective and timely service.

2.2.17 **Duty Team** – This team has not been stable for a long time. A lack of, and changing managers, together with a very transient social work team has put considerable pressure on a small, core group of permanent social workers.

2.2.18 Gaps in service have put considerable pressure on managers who have had to cover the gaps and thus been unable to give time to some of their other duties. The resulting fire-fighting approach has not enabled longer term strategies to be developed and it has been difficult to mentor and develop inexperienced workers.

2.2.19 **Children in Need teams** – The caseloads are high (approximate caseload average: 27 children), many staff are newly qualified and inexperienced with a potential impact on their training and development requirements, causing the vicious cycle of high demands, insufficient training and consequently high stress levels.

2.2.20 This in turn affects experienced workers and managers. Supervision is highly valued by Team Managers and Social Workers but is not provided as frequently nor as in depth as it should be to ensure safety. Without formal risk management tools to provide some structured oversight, this is another area of vulnerability.

2.2.21 **Contact** – Managing supervised contact for children in care has been a recurring theme throughout the audit.

2.2.22 It has been separately raised by social workers, CYPS workers, Admin support workers, 0-11 centre managers and Team Managers as being a key issue which impacts massively on their time to complete other tasks. It is another issue related to capacity.

2.2.23 There has been an increase in the number of children 'Looked After', partly due to the Public Law Outline pre-proceedings protocol and an increase in the number managed within the Children in Need teams.

2.2.24 There is a lack of contact officers and of venues to meet this increased need.

2.2.25 We are currently not able to consistently meet children's needs for contact outside office hours. Contact arrangements are exceedingly time-consuming to set up and are regularly having to be cancelled due to lack of capacity.

2.2.26 **Cases awaiting allocation** – During the period of the audit there were a number of cases awaiting allocation to a social worker in both the Duty and Children in Need teams.

2.2.27 The level of risk identified for some of those in the Duty team resulted in a decision to allocate a case to each Team Manager, further impacting on their ability to undertake their management tasks.

2.2.28 There has been an unprecedented rise in children with child protection plans from 115 in March 2008 to 205 in March 2009 and an increase in children in care from 425 in March 2008 to 480 in March 2009.

2.2.29 To ensure all of these children have a social worker caseloads have increased for existing staff and inevitably some children have to wait.

2.2.30 An exercise as part of the audit identified a number of children requiring social work input in the Children in Need teams with no further capacity to allocate at that time. These children may present more risk than those already subject to protection plans or looked after as their needs are identified but not met.

2.2.31 There is a robust system in place to review these cases and monitor risk. Some of these families will already be receiving services but not making sufficient progress so a re-assessment of their needs is required. Where other agencies can assist in supporting children waiting for a social worker they are asked to do so.

Supervision

2.2.32 Supervision has been identified within the audit as one of the key issues in the process of keeping children safe.

2.2.33 However the range of tasks now expected to be achieved through supervision requires a considerable increase in the amount of time given to it by social workers and Team Managers.

2.2.34 The focus of supervision has been forced to shift from a learning forum to a performance management tool.

2.2.35 The Haringey Joint Area review and the training commissioned in Wigan on Analysis drew the same conclusion – that the opportunity to reflect on information and to receive guidance and mentoring through supervision is vital to ensure safety.

2.2.36 The Joint Area Review criticised too much reliance on quantitative data without analysis of the underlying quality of service provision and practice (JAR Haringey, page 4).

2.2.37 Performance management has an equally important role in monitoring practice.

2.2.38 This includes monitoring the implementation of recommendations from Complaints Investigations and Serious Case Reviews so that lessons are learnt from. However to achieve this, time must be created for both parts of the supervision task.

Outstanding tasks and recommendations:

2.2.39 The following areas remain outstanding and will require attention.

- The audit of caseload numbers and type could usefully be extended to cover all Duty and Children in Need teams.
- Further work is required in conjunction with the Data and Monitoring team to collate information on the geographical distribution of cases. Further work is required to analyse the Team Manager's role and tasks.
- A review of the threshold criteria at the Duty team may assist in prioritising the appropriate cases for Social Care. This would need to include an audit of the number of cases closed at the Duty Support team with no further action.

Recommendations:

2.2.40 Staff at all levels of the service contributed their views. This identified the key issues affecting or preventing good practice 'on the shop floor'. Routine structured ways of collating and addressing staff views and concerns should continue to be undertaken in the future.

2.2.41 In order to ensure workloads are manageable and promote effective work with children and families, a systematic audit of current caseload numbers, type and geographical distribution is necessary to inform the configuration of new Social Care teams under the restructuring programme.

2.2.42 There are two ways to increase social workers' and Team Managers' capacity. Reducing the work allocated to them and by increasing the numbers of workers and managers able to undertake the work.

2.2.43 A review of the threshold criteria at the Duty Team may decrease the number of cases progressing through the service if needs can be met via a Common Assessment prior to a direct referral to social care.

2.2.44 A review of existing services within CYPS to ensure effective early intervention and preventation services target the right children and families and avoid the need for referrals at 3b.

2.2.45 Further developments of administrative support, Contact Service support and children and young people workers will reduce the work required to be undertaken by social workers.

2.2.46 The current establishment of social workers and team managers does not allow for safe allocation and monitoring of cases and a range of options will be discussed under the proposals section of this report.

3. Domestic violence and abuse

3.1 Domestic violence and abuse within families has been a recurring theme throughout the audit and has been raised by all parts of the Children in Need service.

3.2 It was identified from a recent Serious Case Review that an inter agency protocol and structured action plan as well as practice guidance needs to be developed.

3.3 Wigan has an exceptionally high occurrence of domestic violence and abuse and Social Care could respond more effectively to the most serious cases involving children and young people if an effective assessment tool was utilised to screen referrals.

3.4 A very high percentage of referrals to the Duty team involve domestic violence as one of the risk factors.

3.5 The Wigan Safeguarding Children Board and the Domestic Violence Executive arranged for a briefing session by Barnardos on a risk assessment model developed by them and implemented by the pan London Safeguarding Board.

3.6 This was welcomed as a tool to assist in measuring thresholds and undertaking effective assessments.

3.7 A proposal and costings on delivering multi-agency training on this model is being undertaken by Barnardos and will be presented to the WSCB with recommendations to implement this incrementally across all threshold levels and all agencies.

3.8 However it was recognised that a multi-agency awareness-raising approach will result in an increased number of families being identified as needing support and intervention.

3.9 Many of these are likely to be directed to Social Care unless there is also broad dissemination of information about other resources in the community alongside the training.

3.10 This links to another concern that assessment is limited without the resources to intervene and address the identified needs.

3.11 The 0-11 service is developing skills and knowledge amongst the staff team to address the needs of women and children affected by domestic violence but this is a limited facility and one only available to those children whose needs are assessed as being at threshold 3b and 4.

3.12 There is potential to develop service level agreements with the two voluntary agencies within Wigan and Leigh which currently provide support to families.

3.13 There is a significant gap in service provision in the local area for men who perpetrate domestic violence unless they are involved with the Probation service.

3.14 In fact, recent research informs that the traditional (and current) approach of referring men for anger management is in fact an inappropriate and dangerous response.

3.15 This is only one of a number of areas where the Social Care response to domestic violence needs to be adapted and developed.

3.16 There is recognition now that the perpetrator of the violence or abuse must be included and involved in the assessment. However the challenges and risks inherent in this, to both the workers and the women involved, have not been fully explored.

3.17 Consequently there continues to be a focus on the woman as solely responsible for protecting her children, with demands placed on her to leave the violent relationship.

3.18 Again there is rarely full recognition within current practice, of the risk implications to her and the children of doing this, without protection and support.

3.19 The vulnerabilities identified within the current system are therefore:

- The lack of assessment tools
- The lack of robust threshold criteria in relation to domestic violence for Social Care
- The lack of alternative resources within the community to meet the assessed needs
- The lack of intervention and services for the perpetrators of domestic violence
- The lack of support and training to staff to work directly and safely with families
- The need for all schools to be committed to awareness raising and skill development around the resolution of domestic disputes.

3.20 If we are unable to effectively address the causes of domestic violence within local families, which is already inter-generational, we are unlikely to reduce the incidence in the future.

Recommendations:

3.21 The proposed assessment model and training requirements is accepted and funded by the Safeguarding Board.

3.22 A stronger more pro-active working relationship between Social Care and the Domestic Violence coordinator to be developed.

3.23 Formal links in relation to service delivery need to be developed with local voluntary agencies in order to promote a range of interventions with families.

3.24 Consideration is given to commissioning services from established agencies in the wider locality (Warrington, St Helens) in order to better address current needs and meet the likely increased need.

4. The Protection of Children in England – Lord Laming

4.1 The Government asked Lord Laming to report on child protection in England as a matter of urgency following the Haringey Joint Area Report.

4.2 The report was published on 12 March 2009 and made 58 recommendations.

4.3 It is not the intention of this report to comment on all the recommendations which members can read in Appendix 1 but to highlight some key issues particularly those that are also highlighted in Wigan's audit of social care.

4.4 Many of the statements below are paraphrased from the full report to illustrate key points.

4.5 Greater consideration of the multi-agency aspects of the report will be scrutinised by the Safeguarding Board as it considers the amalgamated action plans.

4.6 The introduction of the report states:

> **"One of the main challenges is to ensure that leaders of local services effectively translate policy, legislation and guidance into day to day practice on the frontline of every service. Leaders of local services must recognise the importance of early intervention and prevention and ensure their departments support children as soon as they are recognised as being 'in need', averting escalation to the point at which families are in crisis.**
>
> **Front line staff in each of the key services have a demanding task. Their work requires knowledge and skill but also determination, courage, and an ability to cope with sometimes intense conflict. This must be recognised in their training, case-loads, supervision and conditions of service and their managers must recognise that anxiety undermines good practice. Staff supervision and the assurance of good practice must become elementary requirements in each service. More should be done to ensure well- being and confidence of the staff who undertake such an important task on behalf of us all"**

4.7 This statement alone reflects the key findings of the Wigan audit and clearly demonstrates the issues that are shared across local authorities country wide.

4.8 **Improvement and Challenge**

4.8.1 The Government will introduce new statutory targets for safeguarding and child protection alongside the existing statutory attainment and early years targets as quickly as possible.

4.8.2 The National Indicator Set will be revised with new national indicators for safeguarding and child protection developed for inclusion in Local Area Agreements for the next Comprehensive Spending Review.

4.8.3 A new National Safeguarding Delivery Unit will drive and support reforms.

4.8.4 From April 2009 Ofsted are to undertake "annual unannounced on-site inspections of the quality and effectiveness of arrangements for contact, referrals and assessment processes for safeguarding and child protection work". This is in addition to the full, announced inspections every three years.

4.8.5 The Government is asked to, " take decisive action to protect budgets for safeguarding children" as unlike the greater part of school funding, these are currently not ring – fenced and therefore at risk from pressure on councils to deliver efficiency savings.

4.8.6 **In Wigan** we have reviewed the leadership of our Safeguarding Board and in advance of Laming's recommendations have appointed an interim Independent Chair. It is renewing its business plan to reflect the requirements in respect to Serious Case Reviews and to ensure that it is in a position to both promote, support and challenge safeguarding practice across the Trust.

4.9 Leadership and Accountability

4.9.1 There is great emphasis throughout the report on leadership throughout the system and a sustained commitment locally to children's welfare from council leaders and the Lead Member for children's services.

4.9.2 In order to be most effective, Lead Members must have access to an appropriate level of up to date detail of safeguarding practice for their authority, including an understanding of the profile of children and young people in their area, level of need, and the quality and effectiveness of services that protect children from harm.

4.9.3 They should provide regular scrutiny of key management information, including assessment and inspection reports, and members must assure themselves that appropriate quality assurance systems are in place.

4.9.4 They must ensure appropriate scrutiny and support of the staff they employ to deliver safeguarding services.

4.9.5 **In Wigan** we have recognised the need for training to Elected Members to support them in this role.

4.9.6 An initial session took place on 11th March 2009 and was attended by over 30 Members.

4.9.7 The session provided Members with an overview of information gathering and decision making.

4.9.8 The cases involved demonstrated the importance of information sharing and discussion and advice from an experienced social care manager.

4.9.9 Members appreciated from the case examples the degree of judgement that was needed to elicit a clear and accurate view.

4.9.10 This session was well received with 100% of participants feeling the input had been excellent or good.

4.9.11 This session can be repeated for any Members who were unable to attend and further sessions can be arranged to develop Members ability to understand and therefore more accurately support and scrutinise the social care functions of the Council.

5. Children's Workforce

5.1 This is the longest chapter in the report and identifies " low morale, poor supervision, high case loads, under -resourcing and inadequate training" in children's social care which has led to a recruitment and retention crisis, which good leadership on its own will not overcome.

5.2 It advocates a national strategy to raise the profile of social work and provide more attractive entry routes to the profession.

5.3 The report advocates guaranteed support and supervision and a framework for continuing professional development. It is important to recognise the stressful and emotional content of social work and put measures in place to help staff deal with the emotional content of child protection work.

5.4 Such support needs to be reinforced by a system of good line management that is creative, empowering and sensitive to the individual needs of frontline staff, yet confident enough to set and secure high standards of delivery.

5.5 **In Wigan** we are re-organising our social care services to deliver services across the five areas.

5.6 In doing this we are ensuring that social workers deliver a range of interventions from initial contact through to the outcome of care proceedings should they become necessary and therefore they will not only be dealing with child protection investigations.

5.7 The child protection work will be devolved to five teams not three as at present and proposals around the composition of teams will allow for greater access to supervision and support.

6. Support for Children and Inter-Agency Practice

6.1 This mainly covers frontline practice and argues that caseloads are too high which limits the time social workers and health visitors have to maintain effective contact with children and their families.

6.2 'Thresholds' that act as a gateway to services, are inconsistent, and may be too high resulting in missed opportunities to provide early support to children and avoid situations spiralling.

6.3 Children who fall short of needing a child protection plan are placed at particular risk of suffering harm when services are not provided for them. Local authorities must address this issue urgently and ensure they are providing the range of services and support that children in need require.

6.4 Early intervention is vital and those in universal services must realise this applies to older children too.

6.5 Laming identifies the challenges of working across agency boundaries but emphasises the importance of adult and children's services working effectively together.

6.6 We know that many of the children we work with and who have been subject to serious case reviews locally and nationally live in households were domestic violence (200,000), drug misuse (250,000 - 350 ,000) mental health problems (450,000) and parents who misuse alcohol 1.3 million.

6.7 It is vital that those who provide services to adults who are also parents are mindful of the risks to children and prioritise services that will enable children to remain at home safely.

6.8 Sharing Information still remains problematic with confusion in some services about what information can lawfully be shared.

6.9 The Common Assessment Framework, a tool to aid the early assessment of a child's needs must not become too process – focused.

6.10 Laming recommends that all professional referrals result in an initial assessment. If this is to become practice then it becomes increasingly important that action is taken at an early stage by way of a CAF before a referral is made to social care.

6.11 **In Wigan** we have training across the workforce in relation to information sharing. The introduction of Contact Point later this year will aid earlier contact with agencies already involved.

6.12 We are continuing to increase the number of CAF's undertaken. We have a clear parenting strategy that aligns services and support across the thresholds of need.

6.13 The re-focussing of the Safeguarding Board at levels 3b and 4 will ensure that all partners including adult services are better able to recognise the needs of children in these families and provide earlier support to parents.

7. Key Issues for Change

7.1 Members can see that the Wigan audit and the Laming Report are entirely congruent and that many of the actions already taken or outlined in the audit document will be a positive move towards achieving the aims listed in the Laming report.

7.2 There are however some areas that will be dependent upon the yet to be formed Safeguarding Delivery Unit and others that require a local response.

7.3 **Recruitment and retention**

7.3.1 The report to members in January 2009 outlined the difficulties Wigan faces in recruiting managers and experienced social workers to frontline safeguarding posts.

7.3.2 The Duty service has been unable to recruit managers since summer 2008 and has only two recruited staff out of a complement of 8. The balance being an ever changing number of agency staff.

7.3.3 The Children in need teams whilst able to recruit good quality newly qualified staff has difficulties recruiting experienced staff to undertake complex work and support newly qualified workers with restricted caseloads.

7.3.4 There are a number of actions which are proposed to address these issues:

- The proposed service re-design to reduce the size and tasks of the duty team and to deliver a range of services from five areas will not only provide better services for families by reducing the number of changes of social worker but will provide workers with a range of work as recommended by Laming.

- The Newly Qualified Social Work pilot makes Wigan an attractive place to begin a social work career and the continuing in house trainee scheme provides routes to ‘grow our own’ social workers.

- To retain our existing skilled staff, nurture our new staff and increase the ‘attractiveness’ of Wigan as a social care employer we need to ensure that the quality and quantity of the supervision we offer reflects the complexity and quantity of the workload we expect our staff to undertake.

- Capacity issues have been highlighted throughout this report and a range of measures implemented and recommended to try to address them. However without an increase in the social care work force the current unallocated work will remain at similar levels and staff will continue to carry unacceptably high caseloads.

- Over time, when ICS is fully implemented, administrative support systems changed and fully implemented, prevention and parenting programmes in place with Common Assessment identifying and providing early support a revision of social work numbers can take place.

- First line managers need to receive appropriate financial packages to maintain a differential and have sufficient experienced staff within their teams to share the supervisory task.

- Experienced workers need to be recognised within a salary structure that retains them in practice and does not force them to seek a management position as the only way of career progression. The Advanced social work programme referred to in Laming’s report will eventually achieve this but Wigan needs to act now.

- Proposals to support the provision of quality social work services and adequate supervision and support for staff by increasing the establishment of social workers and extending the grade of social work managers and senior social workers will be discussed in detail with the Director of Children’s Services.

7.4 **Develop a new system to deliver business support**

7.4.1 The Wigan audit demonstrated the benefits to teams in using administrative support differently.

7.4.2 Discussions will be undertaken with Business Support Services to incorporate a team clerk approach to support frontline work

7.5 **Integrated Children's Service**

7.5.1 There is an urgent need to re-define the implementation plan and determine the levels of support needed to the project to ensure implementation.

7.5.2 Discussions are taking place with the application support manager to progress this.

7.6 **E –social care system**

7.6.1 Work will need to be undertaken to scope the development and to assess the costs of progressing this work.

7.7 **Regular reports to Lead Member**

7.7.1 The Head of Social Care will provide reports on social care services at a frequency to be agreed with the Lead Member.

7.7.2 An annual report of child protection activity, staffing and resources will be available to the Overview and Scrutiny Committee.

7.7.3 Further training on Safeguarding and Member's key areas of responsibility will be provided. Such training to be made available on an annual basis open to all Members

7.8 **Audits**

7.8.1 The system of audits developed within the action plan should be continued within social care and on a multi agency basis.

7.8.2 The frequency and content of ongoing audits to be agreed and monitored by the Wigan Safeguarding Children Board.

7.9 **Domestic Violence**

7.9.1 A comprehensive and structured domestic violence strategy to be approved by the Children's Trust Board and the Wigan Safeguarding Children Board

8. Conclusions and Recommendations

8.1 This has been a necessarily long report to ensure members are fully appraised of the issues both within Wigan and nationally as reported by Lord Laming.

8.2 Members are asked to note the content and support the proposed actions highlighted within this report.

8.3 Members are asked to regularly scrutinise progress through this Forum.

Appendix 1

Protection of Children in England – Lord Laming Recommendations

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 services, 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.

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

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 Department for Children, Schools and Families should revise *Working Together to Safeguard 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 Department of Health and the Department for Children, Schools and Families must strengthen current guidance and put in place the systems and training so that staff in Accident and Emergency departments are able to tell if a child has recently presented at any Accident and Emergency department and if a child is the subject of a Child Protection Plan. If there is any cause for concern, staff must act accordingly, contacting other professionals, conducting further medical examinations of the child as appropriate and necessary, and ensuring no child is discharged whilst concerns for their safety or well-being remains.

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 Task Force should establish guidelines on guaranteed supervision time for social workers that may vary depending on experience.

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

17. The Department for Children, Schools and Families 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 the 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 Department for Children, Schools and Families 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 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 Department for Children, Schools and Families must strengthen *Working Together to Safeguard 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 drugs and alcohol misuse using current best practice. This should be shared with local authorities, health and police with an expectation that the assessment of risk and level of support given to such children will improve quickly and significantly in every Children's Trust.

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

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

24. The Social Work Task Force should:

- develop the basis for a national children's social worker supply strategy that will address recruitment and retention difficulties, to be implemented by the Department for Children, Schools and Families. 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 Trusts should ensure a named, and preferably co-located, representative from the police service, community paediatric specialist and health visitor are active partners within each children's social work department.

26. The General Social Care Council, together with relevant government departments, should:

- work with higher education institutions and employers to raise the quality and 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 Department for Children, Schools and Families and the Department for Innovation, Universities and Skills should introduce a fully-funded, practice-focused children's social work postgraduate qualification for experienced children's social workers, with an expectation they will complete the programme as soon as is practicable.

28. The Department for Children, Schools and Families, 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 ensures 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 enables them to understand normal child development and recognise potential signs of abuse or neglect.

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

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 Department of Health 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 Department of Health 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 Healthy Child Programme for 5–19-year-olds.

34. The Department of Health 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 Department for Children, Schools and Families 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 Department of Health 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.

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 Department for Children, Schools and Families should revise *Working Together to Safeguard 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 Department for Children, Schools and Families 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 Department for Children, Schools and Families 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 Department for Children, Schools and Families 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 Department for Children, Schools and Families that supports them in their role in undertaking Serious Case Reviews that have a real impact on learning and improvement.

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 reports 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 summarise the lessons from Serious Case Reviews.

Organisation and finance

50. The Department for Children, Schools and Families 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 chair should be selected with the agreement of a group of multi-agency partners and should have access to training to support them in their role.

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

54. The Department for Children, Schools and Families, the Department of Health, 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 Department for Children, Schools and Families 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'.

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

57. 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.