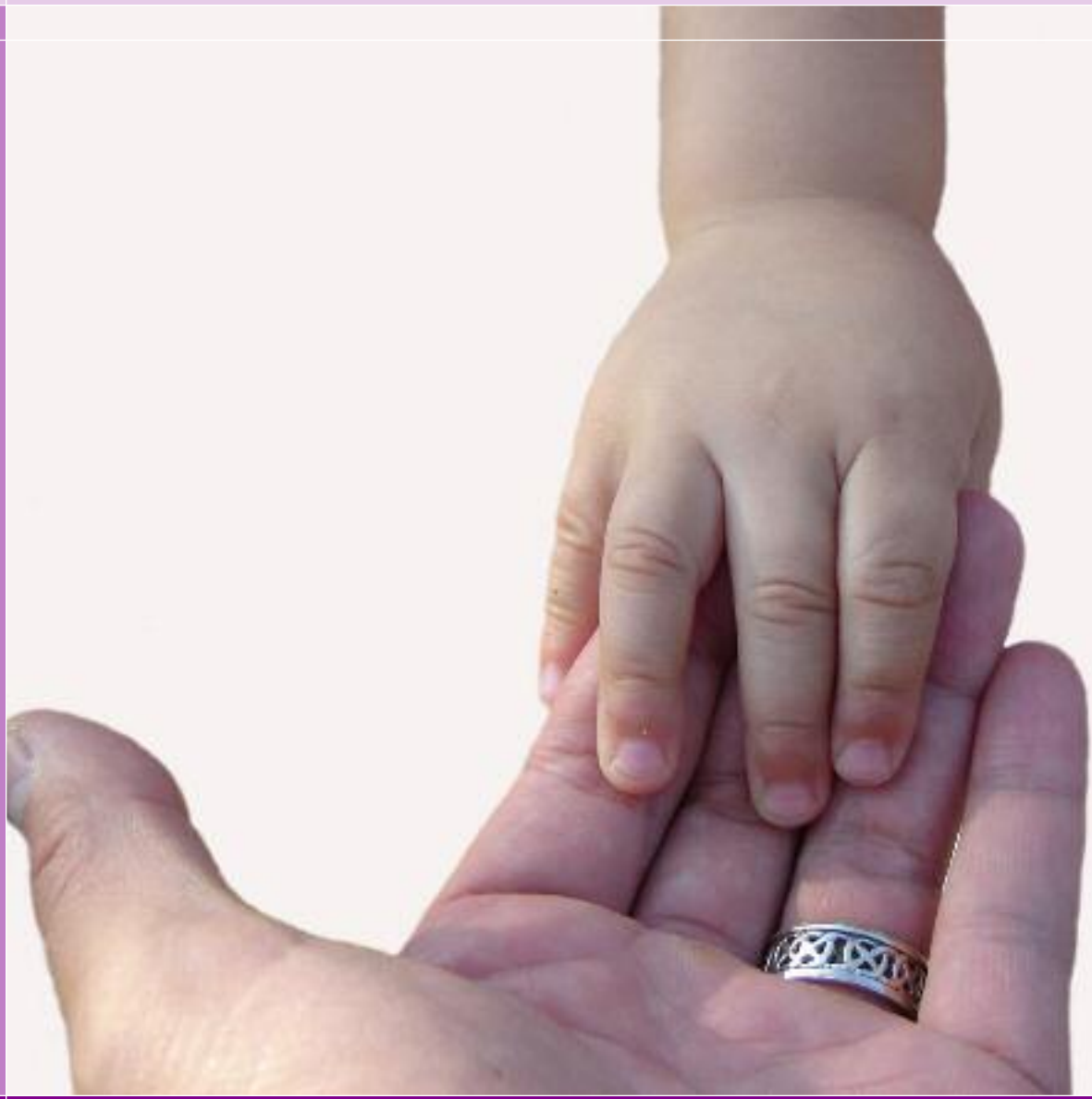
safeguarding children – literature review

Local Government Education and Children's Services Research Programme



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Additional information

This literature review refers to documentation published before the UK's new Coalition Government took office in May 2010. As a result, some of the practice outlined may not reflect current government policy or guidance, and may make reference to the Department for Children, Schools and Families (DCSF), which has now been replaced by the Department for Education (DfE).

Executive summary

Background

In March 2009, Lord Laming published the findings of a review investigating the progress being made across the UK to implement effective arrangements for safeguarding children. The review was commissioned by the Secretary of State for Children, Schools and Families in response to the case of Peter Connelly, known as Baby Peter, being made public in November 2008. It stated the need for 'a step change in the arrangements to protect children from harm' (DCSF, 2009, p.4).

In June 2010, Professor Munro was commissioned by the new Coalition Government to conduct an independent review of child protection in England. In the review's first report, published in October 2010, Munro sets out the review's intended approach and the features of the child protection system that need exploring in detail (Munro, 2010). Following initial feedback from a wide range of stakeholders, Munro suggested that 'good practice thrives' (p.42) in many parts of the country despite the numerous system-level challenges that are yet to be resolved.

Aims of the study

The purpose of this study is to identify any evidence of changes and improvements in safeguarding practice since the Laming review. It distils current learning about the challenges and identifies factors which are supporting improvements in safeguarding work. This literature review builds on learning from an initial scoping study carried out by the NFER for the LG Association earlier in 2010, which set out relevant literature on safeguarding practice published since the Laming review in 2009 (Atkinson, 2010). It should be noted that this review provides an indication of some of the developments in safeguarding practice rather than a comprehensive research evaluation of progress in safeguarding activity *per se*.

Key findings

Training and professional development

Training and professional development of social workers

Ofsted's first annual survey of social work practitioners across local authorities in England suggested that the training and professional development of social workers has progressed considerably since the Laming review (Ofsted, 2010a). The survey found that, in general, social work practitioners are positive about their training experiences in relation to safeguarding. The majority of respondents also reported that such training helps them to understand and meet the needs of children and young people.

Supervision of social workers

Ofsted (2010a) offered a positive view of line management arrangements for social work practitioners. The majority of respondents reported that their line manager supports them to manage risks arising in their casework, access appropriate training and manage their workload. However, improvements in providing high-quality supervision may not be widespread. Hunter (2009), cited in Burton (2009), for example, reported that levels of appropriate supervision are the same as they were following the first Laming review in 2003 and, in some cases, the provision has actually worsened.

Training and development of other professionals

An Ofsted survey (2010b) found that third-sector organisations are positive about the safeguarding training available from their local safeguarding children board (LSCB). Improved training for and development of health professionals is also evidenced in a review of the four NHS trusts involved in the Baby Peter case. In other areas, however, the provision of safeguarding training for health workers appears less encouraging,

particularly in relation to the allocation of safeguarding training budgets, and the provision of safeguarding training at levels 1 and 2 (Care Quality Commission, 2009).

Challenges

The challenges associated with training and professional development in relation to safeguarding include the need to encourage critical reflection. Social workers can then increase their capacity to make effective decisions by critiquing their own judgement when considering cases (Burton, 2009). In addition, Barlow and Scott (2010) reported that specific safeguarding training is required to support professionals working in multi-disciplinary teams.

Capacity and recruitment

Capacity and recruitment of social work practitioners

There is a range of evidence to suggest that, following the publication of the Laming review in 2009, commitments have been made across both local and central government to further support professionals in safeguarding children, through greater investment in resources, training and professional supervision. At a policy level, for example, the previous government responded to the recommendations of the Social Work Taskforce (SWT) (HM Government, 2009, p.2) by saying it would undertake wide-ranging and sustained reform of the social work profession.

Capacity of other professionals

There have been developments at a policy level to support other professionals who work with children. For example, the Department of Health has committed to the Action on Health Visiting Programme in response to Laming's recommendation that the numbers of health visitors should be increased (Ly, 2009). However, there is concern that, at ground level, the necessary resources are not always available for implementing policy recommendations.

Challenges

Perceptions about social workers and the public profile of social work result in negative professional morale (Barlow and Scott, 2010) and impact on the recruitment and retention of social workers. Other challenges relate to high workloads, which have implications for the quality and timeliness of social workers' work (MacLeod *et al.*, 2010). These are compounded by bureaucracy constraints imposed by electronic recording systems, management information systems and the Integrated Children's System (ICS).

Relationships and understanding

Methods used to develop relationships and understanding

A recent report by the Children's Commissioner (2010) highlighted social care professionals' qualities and skills conducive to building relationships with children and families. These include good communication skills and being caring. However, the report also highlighted that many social care staff feel that, given the short-term nature of their work and being part of a system where families are moved on following the completion of an assessment, they do not always have the time required to invest in and achieve good relationships.

Challenges

Developing good relationships and understanding with parents is paramount. A number of sources identify the challenges practitioners face when trying to engage with families who are resistant to social care support or are otherwise hard to reach. Challenges were also identified when trying to engage with vulnerable children and young people and children, thus placing them at increased risk of harm.

Interagency working

Interagency communication and information sharing

The findings of Holmes *et al.* (2010) suggested that agencies are continuing to develop and improve their information sharing. However, the same study also suggested this can be improved further. Ofsted's (2010a) survey of social work practitioners found that fewer than half of respondents agree that communication and information sharing is effective both within their local authority and with other

organisations contributing to safeguarding children. Within the health sector, the Care Quality Commission (2009) found that just over a third of applicable acute trusts do not have a policy in place for joint working between maternity services and social services.

Interagency working

Barlow and Scott (2010), based on findings from their literature review, reported that universal services[1] are ideal for assessing families, particularly during pregnancy and the postnatal period. As such, they argued that there is a need to establish trans-disciplinary teams, which place social workers within the heart of teams working in children's centres, schools and perinatal services. Barlow and Scott identify local examples of the development of such teams.

Challenges

The review found that effective interagency working could be limited by historical and cultural differences between professionals and disciplines. Accountability issues arise if there is a lack of understanding of the roles and responsibilities of different agencies.

Quality assurance and monitoring

Tools used for quality assurance and monitoring

Fish (2009) concluded that increased significance is being given to local auditing. Whilst there does not appear to be a great deal of literature about local auditing after the Laming review was published, Fish drew attention to a number of local examples where audit tools are being used effectively. Such tools include self-audits, case file reviews, questionnaires for professionals, volunteers and members of the public, and consultations with those using the services.

Application of quality assurance procedures

Some agencies are not applying quality assurance procedures in a satisfactory way. The Care Quality Commission's (2009) report on NHS arrangements for safeguarding children found, for example, that the frequency with which boards monitor compliance with their safeguarding responsibilities varies, but this usually takes place on an annual basis or when they are notified about serious incidents (Care Quality Commission, 2009). The report also found omissions within the processes covered by child protection policies, and was particularly concerned by the absence in many NHS trusts of follow-up procedures for children who have missed outpatient appointments.

Role of performance indicators

Fish (2009) says, following the publication of the Laming review, many local authorities have put into place plans for adapting their systems for measuring performance in order to monitor the quality of safeguarding practices. Many local authorities, according to Fish, defend the use of performance indicators as a tool for ensuring their accountability, indicating that they remain a 'necessary measure of the quality of decision-making and organisational supports' (p.11).

Serious case reviews (SCRs)

Conducting SCRs

Ofsted (2009) reported that SCRs are being carried out more speedily and LSCBs are becoming more rigorous in their scrutiny of individual management reviews and overview reports. The Ofsted survey (2010a) of social work practitioners also indicated that, since the Laming review, learning from SCRs is being communicated more effectively. Within the health sector, the Care Quality Commission (2009) found that two-thirds of reviews are completed and signed off within one to three months, and that, in most cases, action plans and recommendations arising from SCRs are given to the responsible service managers.

Challenges

Challenges relate primarily to communication and collaboration between professional agencies involved in working with children. For example, there were instances where health practitioners had noted the signs and symptoms of potential abuse, but had not communicated these to other professionals or agencies. Amongst education professionals, the use of the

Common Assessment Framework (CAF) is not always fully embedded and where SCR panels need to examine the childhood histories of teenage parents, they are often hindered due to school records being unavailable as they have been destroyed in accordance with local record retention policies.

Referrals and assessment

The development of referrals and assessments

The changes made to local authorities' referral, assessment and supervision processes after the Laming review include greater managerial overseeing of cases, strengthened audit systems, and developments or changes to supervision policies. However, in an evaluation of SCRs conducted between 1 April and 30 September 2009, Ofsted (2010c) found that 'referrals, primarily by health and social care professionals, were not always followed up sufficiently rigorously'.

Challenges

The significant increase in the number of referrals and demands for placements received by social care teams in the wake of the Baby Peter case has increased the pressures on social care teams. There are concerns that a great deal of staff time is spent signposting to other agencies and responding to initial contacts which are below the threshold for statutory intervention (MacLeod *et al.*, 2010). There are also concerns that, as a result of the Laming review, attention is focused on cases similar to Baby Peter's, thus inadvertently diverting attention away from other groups of vulnerable children (Garboden, 2010a).

Concluding comments

Evidence of changes and improvements in safeguarding practice after the Laming review

A reasonable amount of evidence of changes and improvements in safeguarding practice is identified in this review. However, given the relatively short amount of time since the Laming review (approximately 18 months), it is perhaps unsurprising that published literature setting out specific developments in safeguarding practice, as a result of Laming's recommendations, is fairly limited.

A further issue in exploring changes and improvements in safeguarding practice since the Laming review is that it is very likely that many of the shifts in local authority practice are documented in internal (unpublished) plans and procedures. Others may be less tangible, such as cultural changes, and, therefore, are more difficult to record. Similarly, any formal evaluation of changes in safeguarding practice at a local level is likely to be currently ongoing and yet to be published.

Evidence of challenges and supporting factors in making improvements in safeguarding practice

The evidence reviewed here highlights the many challenges that remain in implementing Laming's recommendations. These findings will be used to inform the research framework for the next study in this series of reports on safeguarding children to be conducted by the National Foundation for Educational Research (NFER) for the LG Association. It will evidence key learning from five English local authorities that have improved their performance in safeguarding children, according to recent inspections. This work is due to be published in spring 2011.

Notes

1 The key universal services for children and young people are GPs, health visitors, midwives and school nurses, early education and childcare, primary and secondary education.

1 Introduction

1.1 Background

In March 2009, Lord Laming published the findings of a review investigating the progress being made across the UK to implement effective arrangements for safeguarding children. The review, which was commissioned by the (then) Secretary of State for Children, Schools and Families in response to the case of Baby Peter Connelly being made public in November 2008 set out to evaluate progress since Laming's first report, published in 2003 in response to the death of Victoria Climbie. The review stated the need for 'a step change in the arrangements to protect children from harm' (DCSF, 2009, p.4). The response to the Laming review prompted the previous Labour Government to increase national leadership and accountability in respect of child protection. It wanted to extend accountability beyond the remit of the social work profession to encompass a growing role for other agencies such as the police, education and health professionals. Supporting the reform of child protection services across England, a cross-departmental National Safeguarding Delivery Unit (NSDU) was established in July 2009 to support the safeguarding system nationally, regionally and locally.[2]

At a local level, there has been a mixed response to the Laming review. Previous research by the NFER for the LG Association has shown, for example, that local authorities are broadly supportive of the principles underpinning Laming's review. However, the degree to which they are likely to be able to make changes is contingent upon a range of workforce developments and resolving resourcing issues (MacLeod *et al.*, 2010). Research by Loughborough University, also on behalf of the LG Association, similarly indicated that there are capacity issues when implementing Laming's recommendations. In particular, there are capacity issues relating to the recommendation that all referrals into social care should lead to an initial assessment (Holmes *et al.*, 2010).

In June 2010, Professor Munro was commissioned by the Government to conduct an independent review of child protection in England. In October 2010, Munro set out the review's intended approach and the features of the child protection system that need exploring in detail (Munro, 2010). Following initial feedback from a wide range of stakeholders, Munro suggested that 'good practice thrives' in many parts of the country despite the numerous system-level challenges that are yet to be resolved (Munro, 2010, p.42).

It is clear that there are numerous challenges to be addressed if the demands of government policy and the realities of working practice are to be balanced and the best possible outcomes for children realised. As such, further understanding is required to ensure that professionals are well equipped to respond to the needs of children and young people. This means having streamlined practices, effective working relationships with other agencies, and the autonomy to make professional judgements without undue bureaucracy.

The purpose of this review is to identify any evidence of changes and improvements in safeguarding practice since the Laming review. It distils current learning about the challenges and identifies factors which are supporting improvements in safeguarding work.

1.2 Methodology

This literature review builds on learning from the initial scoping study carried out by the NFER for the LG Association early in 2010. It set out relevant literature on safeguarding practice published since the Laming review in 2009 (Atkinson, 2010). This present review identifies subsequent publications (from March 2010 to October 2010). Both studies implemented the same search strategy. Documents were gathered via three separate exercises:

strand 1: search of relevant research databases

strand 2: search of a selection of local authority, government and relevant national organisations' websites

strand 3: direct request for additional documents sent to a small number of key contacts with relevant expertise and practice knowledge.

Documents from the earlier scoping study were combined with those in the present review and assessed for relevance to the research aims. A total of 36 sources were included in the review. They comprise research literature, official publications (for example, government reports) and publically available local authority documentation. Further details of the methods used in this research are provided in Appendix 1.

1.3 About this report

This report presents an analysis of evidence that documents changes and improvements in safeguarding practice since the Laming review in March 2009. A broad range of literature was identified through the search for relevant sources. The report also draws upon the first report of the Munro review of child protection, to identify the next steps in improving safeguarding practice.

In conducting a review of such **practice-based** developments, identifying sufficient and relevant evidence presented a number of specific issues.

- **Access to literature focusing on changes in safeguarding practice since 2009**. It is likely that there have been numerous developments in safeguarding practice across England and Wales following the Laming review. However, access to relevant evidence for this review was restricted to changes documented in publically available literature, or that which could be shared with the research team, which may have prevented the inclusion of other, relevant (but less accessible) evidence. For example, some shifts in local authority practice may only be documented in internal or confidential plans, and procedures and other changes may have resulted in less tangible differences such as cultural changes, which are potentially more difficult to verify across a range of service areas.

- **Discerning whether noted changes in safeguarding practice are a direct response to the Laming review**. It may be that changes are a result of ongoing efforts to achieve improvements (such as those determined by priorities at the local level).

- **The short period of time in which to demonstrate impact**. The time elapsed between March 2009 and October 2010 is a relatively short period in which to observe and document impact of any changes introduced since the Laming review. This reduced the likelihood that relevant evidence would simultaneously document practice changes and an analysis of associated impacts.

Given these limitations, it should be noted that this report provides an indication of developments in safeguarding practice rather than a comprehensive research evaluation of progress in safeguarding activity *per se*.

Notes

2 The NSDU was disbanded by the Government in June 2010. The Safeguarding Group within the Department for Education retains lead responsibility for the Government's child protection policy.

2 Safeguarding practice: how have things developed?

This chapter presents evidence from recently published literature on the changes and improvements in safeguarding practice since the Laming review. It also explores some of the supporting factors that have helped to facilitate these changes, as well as some challenges in the ongoing development of safeguarding work.

Examples of approaches to develop safeguarding practice (as identified in the literature) are categorised into seven key areas. They include:

- training and professional development
- capacity and recruitment
- relationships and understanding
- interagency working
- quality assurance and monitoring
- SCRs
- referrals and assessment.

Each of these seven key areas is discussed in detail. They highlight relevant findings in the Laming review and provide an analysis of the literature related to each area.

2.1 Training and professional development

2.1.1 What did the Laming review say about training and professional development?

The review highlights the importance of staff being trained and supported so that they are appropriately attuned to the needs of a child. It draws attention to how the challenges and opportunities created by the complexity of children's social care impact on providing appropriate professional development. Laming argued that 'social work [should be] carried out in a supportive learning environment that actively encourages the continuous development of professional judgement and skills' (Laming, 2009, p.32).

With this in mind, some examples of approaches taken to develop training and support for social workers and other professionals working with children and families are highlighted. These include some of the issues and challenges involved and cover:

- training and professional development of social workers
- supervision of social workers
- training and support for other professionals.

2.1.2 What does the recent literature tell us about the training and professional development of social workers?

Ofsted (2010a) carried out its first annual survey of social work practitioners across local authorities in England on the subject of safeguarding and looked-after children. It appears to suggest that the training and professional development of social worker practitioners has progressed considerably since the Laming review and, in general, practitioners are positive about their training experiences in relation to safeguarding. In particular, the majority of social work practitioners agree (or strongly agree) that their training and development needs are identified through formal appraisals. They agree that sufficient and relevant training is made available via the local authority such that it helps them to keep up to date with legislation and good practice requirements. The majority of respondents also report that such training helps them to understand and meet the needs of children and young people (Ofsted, 2010a).

In direct response to the Laming review, Hertfordshire County Council has developed an academy for newly qualified social workers, those with fewer than six

months' experience post qualifying. The academy provides induction and training for up to 30 social workers at a time. The overall aim is to improve the recruitment and retention of frontline children's social work staff. The academy is also working to increase the involvement and participation of young people in the training of social work staff (Morris, 2009).

2.1.3 What does the recent literature tell us about the supervision of social workers?

The Laming review recommended that social work be underpinned by regular, high-quality, organised supervision in order to promote reflective practice and serve as an outlet for the severe emotional and psychological stresses under which child protection staff operate (Laming, 2009). The recent survey of social work practitioners by Ofsted offered a positive view of line management in the profession. The majority of respondents report that their line manager supports them to manage risks arising in their casework, access appropriate training and manage their workload. A majority also report that they are able to express concerns to their line manager and, in just over half of cases, these concerns are dealt with satisfactorily (Ofsted, 2010a).

Cooper (2010) set out an example of improved supervision practices at Haringey Borough Council. The article cited Peter Lewis, the Director of Children's Services, who said that, following the Baby Peter case, the local authority had:

> *[...] brought in additional training and support, especially direct support to make sure that managers really understand the issues frontline workers are facing in safeguarding.*
>
> Cooper (2010, p.22)

A social worker in Haringey also commented that:

> *We finally feel that our senior managers are aware and appreciative of the work carried out on the frontline in our day-to-day work [...]. Frontline workers now feel that they can challenge management decisions and that our professional judgement is considered.*
>
> Cooper (2010, p.22)

Another example is the peer support approach being implemented in Bath and North East Somerset Council. It involves a two-day training course followed by two-hour group discussion sessions every six weeks for practitioners adopting the lead professional role (which includes social workers). The aim of this is to give staff additional support with some of the practical issues that come up during day-to-day practice (Community Care, 2010).

Such improvements in providing high-quality supervision may not necessarily be widespread. Hunter, for example, reported that levels of appropriate supervision are, in the main, the same as they were following the first Laming review in 2003, and, in some cases, provision has actually worsened (Hunter cited in Burton, 2009).

Box 1 sets out some key messages relating to the training and support of social work staff and other professionals.

Box 1 Developing critical judgement and training of social work staff: what are the challenges and supporting factors?

Encouraging reflective practice

Corresponding to the importance placed on reflective practice within the Laming review, Burton (2009) made the case that social workers are able to increase their capacity to make effective decisions by critiquing their own judgement when considering cases, and cites Munro who said:

> *The most effective corrective to initial biases, misjudgements or the subsequent clinging to erroneous belief despite new evidence, is for social workers to play their own devil's advocate: taking the opposite view to their own view and arguing for that opposing view.*
>
> Burton (2009, p.5).

Safeguarding training for school staff at all levels

Bandele (2009) reported on safeguarding training within the education sector and concluded that schools need to offer all staff (including management) appropriate safeguarding training in order to ensure they are confident about what is expected of them in their day-to-day work in terms of safeguarding children and young people.

2.1.4 What does the recent literature tell us about the training and development of other professionals?

A survey of third-sector organisations by Ofsted (2010b) had positive responses about the safeguarding training available from LSCB. Of those organisations that said training is available to them (57 per cent), most are receiving the training free of charge and believe it to be of a high standard. One third-sector representative said:

> *Offering free training to all staff and ensuring that sessions are running at different times* [allows] *us to send staff at different times. Training that is accredited is now provided. Information is sent out to service providers on a regular basis which is informative and useful.*
>
> Ofsted (2010b, p.14)

Third-sector organisations also made suggestions for further improving safeguarding training. These included LSCBs offering outreach training opportunities (at third-sector organisation premises if there are numbers of staff to merit this), and offering increased amounts of level 1[3] safeguarding training (Ofsted, 2010b).

Improved practice, in relation to the training and development of **health professionals**, was evidenced in a review of progress made since the joint area review of the four NHS trusts involved in the Baby Peter case.[4] The review found that the recommendation that all four trusts should ensure **staff are clear about child protection procedures and receive safeguarding training** appropriate to their role has been met. All four trusts also have systems for ensuring that all incidences of staff not attending training are followed up (Care Quality Commission, 2010). In addition, Haringey Teaching Primary Care Trust (PCT) has arrangements for monitoring the training of relevant staff in the trusts from which they commission children's services. They have appointed a primary care nurse to focus on improving training and development; and a GP, with a special interest in safeguarding, has joined the GP lead for safeguarding to provide specific clinical leadership. The trust has also **increased supervision** for health staff, and the Care Quality Commission (2010) suggested that this has improved staff confidence in raising safeguarding issues.

Progress in engaging GPs in the safeguarding agenda is also evident in other areas. For example, a recent safeguarding children annual report by Stockport NHS stated GPs' engagement has increased due to briefings and quarterly education sessions for GP safeguarding leads. These include sharing learning from SCRs and management reviews (Stockport NHS, 2010).

In other areas, providing safeguarding training for health staff appears less encouraging. For example, the Care Quality Commission (2009) report on arrangements in the NHS for safeguarding children found that only a third of NHS trusts have a **dedicated budget for training in safeguarding**. The report also found that only a half of eligible staff have up-to-date training on safeguarding at level one, which is intended to be available to all staff. Training at level two was also of concern: an average of just 42 per cent of eligible surgeons, anaesthetists and theatre nurses in acute trusts are up to date. The situation is a little more positive amongst paediatric inpatient, day case and outpatient staff: 65 per cent are up to date. In PCTs, only 35 per cent of eligible GPs had up-to-date level-two safeguarding training (Care Quality Commission, 2009).

2.1.5 The Munro review: next steps

The first report of the Munro review of child protection (Munro, 2010) highlighted the importance of social workers' training and professional development in supporting system change related to child protection. The report also emphasised the commitment of the Government to continuing the reform of the social work profession. The review team intend to work closely with the Social Work Reform Board (SWRB) to identify the key principles underpinning 'good social work' (p.10) and consider how to bring about system-wide improvements to ensure social workers are

supported and provided with opportunities for critical reflection, in recognition of the highly skilled role they perform.

Munro will also work with the SWRB to build upon the recommendations of the Social Work Taskforce (SWT). This will include:

> *The development of a new set of standards for the profession and a single, nationally recognised career structure for social work, with clear progression routes and expectations at each stage of a social worker's career.*
>
> Munro (2010, p.7)

Munro also intends to make specific reference to training and development in relation to assessment procedures. In the first report, she argued that:

> *The training and development aspects of assessment, that is the skills to assess well, are central to any future advice about how to improve this critical and fundamental part of work to protect children and young people.*
>
> Munro (2010, p.32).

2.2 Capacity and recruitment

2.2.1 What did the Laming review say about capacity and recruitment?

Emphasis was placed on the pressures faced by frontline social workers and social work managers. The review identified that:

> *Low staff morale, poor supervision, high case-loads, under-resourcing and inadequate training each contribute to high levels of stress and recruitment and retention difficulties.*
>
> Laming (2009, p. 44)

Waterman (2009) identified eleven recommendations in the Laming review relating to the capacity of staff to protect children from harm.

This section highlights some examples of approaches taken to develop the capacity and recruitment of social workers and other professionals and some of the issues and challenges involved in doing so.

2.2.2 What does the recent literature tell us about developing the capacity of social workers and other social care staff?

There is a range of evidence to suggest that, following the Laming review, commitments have been made to support the capacity of a range of professionals in safeguarding children. At a policy level, for example, the previous government committed to a sustained and wide-ranging reform of the social work profession in response to the recommendations of SWT. The SWT recommended new standards for employers to:

> *[...] ensure that all employers put in place the conditions that social workers need to practise effectively, including high quality supervision, time for continuing professional development and manageable workloads.*
>
> HM Government (2009, p.2)

At the local authority level, there were several examples of the number of social care practitioners increasing and workloads being reduced. In Barking and Dagenham, for example, children's services have realigned service-wide priorities to support the development of additional social workers to assist in reducing caseloads (Cullum, 2010). Similarly, in Medway, following their local audit response to the Laming review, the local authority secured additional resources to add capacity in their integrated teams by recruiting family support workers. The aim was to:

> *[...] enhance early intervention and preventative work as well as support the difficult decision-making at the front line to ensure effective multi-agency interventions to address risks to children.*
>
> Collinson (2009, p.5)

Cooper (2010) indicated that supporting social workers after the Laming review has been a major focus in Haringey Borough Council. As well as achieving greater stability in staffing groups (from frontline social workers to senior management), social work staff have benefited from improvements to the ICS and an increase in administrative support. One social worker said:

> *The most significant changes for us have been the improvements in the ICS – we had all been complaining about unnecessary complexity and repetition of the forms that we were required to complete. The changes to ICS*

have significantly reduced workloads and mean that we spend less time in front of the computer. Having more time to spend with families means we can do our job, safeguarding children, so much better.

Cooper (2010. p.21)

Box 2 sets out the some of the challenges and supporting factors in developing the recruitment, retention and capacity of social workers.

Box 2 Developing the recruitment, retention and capacity of social workers: what are the challenges and supporting factors?

Perceptions of social workers and the profile of social work

A number of sources indicate that the public perception and media portrayal of the social work profession present a challenge to practitioners. For example, MacLeod *et al.* (2010) reported that there appears to be a widespread negative impact on morale since the case of Baby Peter, particularly amongst frontline child protection workers. Holmes *et al.* supported this view, stating that 'low morale and anxiety about vilification and/or fears concerning another Baby Peter may increase the time frontline staff spend considering cases' (2010, p.46). Garboden (2009) and Barlow and Scott (2010) also reported that social workers are subjected to high levels of scrutiny, which has led to them becoming demoralised and the public devaluing social work as a profession.

However, there is also some evidence to suggest that this high profile has created a momentum that is bringing about changes in the profession. Holmes *et al.*, for example, reported that the high profile of social work has:

[...] helped secure resources and/or given a renewed impetus to implementation of projects aimed at strengthening practice and promoting integrated working to safeguard children from harm.

(2010, p.8)

Garboden also reported that:

[...] following the Peter Connelly case, there's a clear effort by government and hopefully the social work profession itself not to be defensive and instead use this as an opportunity to take the profession to a new level.

Garboden (2009, p.20)

Indeed, Cooper cited the Director of Children's Services in Haringey, who suggests that this pressure has led to increased focus on bringing about positive change. The director said: 'the pressure is part of what helps one to get on and do things and maintain the pressure and momentum' (Cooper, 2010, p.20).

Retention and recruitment of social care staff

A number of sources indicate that there are challenges in developing safeguarding practice due to difficulties related to the recruitment and retention of qualified social workers. MacLeod *et al.* (2010), for example, reported that, anecdotally, there is a view that child protection social work may have become a less attractive career choice. The same study reported long-standing problems retaining staff, increased stress and overwork. Since the Baby Peter case, MacLeod *et al.* said there has been greater long-term absences and the attrition of more experienced staff.

Indeed, Holmes *et al.* (2010) claimed that staff retention has been affected as a result of concerns about accessing professional development opportunities and emotional support. Ofsted's survey of social work practitioners in 2010 found that, in some cases, caseloads for newly qualified social workers are too high. Twenty-five per cent of social workers with less than 12-months' experience disagree or strongly disagree that their caseloads are sufficiently protected to allow them to undertake their responsibilities in relation to safeguarding children and young people (Ofsted, 2010a). This could impact on their decision to remain in the profession.

Newly qualified social workers

Barlow and Scott highlighted the 'importance of social workers being selected for training on the basis of not only educational qualifications, but also in terms of their personal qualities and development' (2010, p.104). They also highlighted the importance of social workers being recruited on the basis of their ability to become 'fully reflective practitioners'.

Higher workloads

There is evidence to suggest that a wide range of professionals contend with high workloads in relation to their duties to safeguard children. This has implications for both the quality and timeliness of their work (MacLeod *et al.*, 2010). The Children's Commissioner for England (2010) reported that many professionals feel overwhelmed and overworked in this respect. These findings are supported by Ofsted's (2010a) survey of social work practitioners. It found that 64 per cent disagree or strongly disagree that they have 'time to work as effectively as they would wish to with children and young people' (2010a, p.13). Reasons cited include levels of paperwork, time spent recording information electronically, and volume of work.

Bureaucracy

Holmes *et al.* (2010) reported the frustrations of frontline staff when working with electronic recording systems, management information systems and the ICS. In particular, they noted the detrimental impact these systems can have on efficiency of practice due to time spent duplicating information. Holmes *et al.* found that 87 per cent of reported time is spent on activities such as information gathering, liaising with other professionals, discussing cases with a team manager, travel for visits and paperwork. Social workers report that time spent on paperwork is detrimental to their capacity to understand and identify issues for children and families.

Ofsted's (2010a) survey of social work practitioners found that whilst almost a third of respondents agree the electronic case recording system is effective, almost a half disagree. These views are echoed by the findings of the Children's Commissioner for England, which found that professionals feel that paperwork and computer-based activity make engagement with families more difficult. Barlow and Scott (2010), in reporting the findings of Worrall-Davies and Cottrall (2009), echoed this view, saying that bureaucracy and procedures can lead to 'stifled creative planning' (Barlow and Scott, 2010, p.95).

2.2.3 What does the recent literature tell us about developing the capacity of other professionals?

There have been developments at the policy level to support professionals other than social workers who work with children. For example, the Department of Health has committed to the Action on Health Visiting Programme in response to Laming's recommendation that the numbers of health visitors should be increased (Ly, 2009).

In addition, the review of progress since the joint area review of the four NHS trusts involved in the Baby Peter case found that the recommendation that the trusts must work together to ensure that they have a sufficient number of qualified paediatric staff available when required has almost been met. In 2009, Haringey Teaching PCT conducted a review of paediatric staffing, which led to a £2.5 million investment to increase the number of staff in the trust. Of this, £1.25 million was invested in Haringey Community Children's Services run by Great Ormond Street Hospital for Children. The trust placed an emphasis on increasing the number of health visitors and has concentrated their role on safeguarding children with some of their other functions being transferred to GPs, midwives, health visitor assistants and administrators (Care Quality Commission, 2010).

However, the extent to which such policy changes have been translated into practice across the country is debated. For example, Ly quoted the views of a health visitor in response to the Action on Health Visiting Programme, who said there is a 'gap between what is written on paper and what is being done on the ground' (2009, p.13). This stems from the issue that policy recommendations do not always translate into the necessary resources for professionals to implement them effectively at ground level.

The recent literature also suggests that there are variations in the extent to which different professionals have capacity to fulfil their safeguarding duties. For example, the Care Quality Commission's (2009) report on arrangements in the NHS for safeguarding children found there is a difference between doctors and nurses in terms of the protected time they have available for safeguarding duties. Designated and named doctors have approximately one day per week, whereas named nurses have three to four days per week (Care Quality Commission, 2009).

2.2.4 The Munro review: next steps

The first report of the Munro review echoed this literature review in suggesting that the challenges posed to the social work profession in relation to the recruitment and retention of staff is ongoing, particularly in the face of intense media and public scrutiny. Munro argued that such challenges make it 'difficult [for social workers] to provide the flexible and sensitive responses that match the wide variety of needs and circumstances that are presented' (Munro, 2010, p.7). As a consequence, the Munro review will consider 'how the media and public are helped to have a better understanding of the complexity of decisions, and the uncertainty that professionals live with each day' (Munro, 2010, p.42).

Munro also addressed the particular challenges raised by local ICS systems. Following the removal of the mandatory requirements in relation to ICS, the review will seek to understand the impact of these changes, and address variation in the flexibility of ICS systems across local authorities. Looking beyond ICS systems, the review will also consider how IT can be used to actively facilitate effective child protection practice, through the use of tools and systems that support social work, rather than inhibit it.

2.3 Relationships and understanding

2.3.1 What does Laming say about relationships and understanding?

The Laming review placed great emphasis on fostering effective relationships with children and their families, saying, for example, that staff across frontline services should be equipped to ensure that 'as far as possible they put themselves in the place of the child or young person and consider first and foremost how the situation must feel for them' (Laming, 2009, p.22).

This section highlights some recent examples of approaches taken to develop relationships and understanding. The challenges and supporting factors for the development of effective relationships are also outlined.

2.3.2 What does the recent literature tell us about methods used to develop relationships and understanding?

In drawing together information from various government guidelines about how schools can contribute to safeguarding, Bandele emphasised the importance of a 'commitment to an open and honest relationship and involvement of parents and carers at all stages of a child or young person's education and care' (2009 p.26).

Similarly, a recent report by the Children's Commissioner for England (2010) highlighted the qualities and skills of social care staff that are conducive to building relationships with children and families. This includes having good communication skills; being caring; demonstrating respect; understanding the barriers; working in partnership; and having sufficient knowledge and expertise. Many of the family members involved in this research reported that it is particularly beneficial when information is shared in advance. The report quoted one family member as saying:

> *What was positive about our experience is that we had all the information together and if people wanted to say bad things, they said the bad things there and if they wanted to say good things, they said them, because we were all talking to each other.*
>
> Children's Commissioner (2010, p.41)

However, this report also highlighted that many social care staff feel that given the short-term nature of their work, and being part of a system where families are moved on following the completion of an assessment,

they do not always have the time needed to invest in and achieve good relationships.

Other evidence suggests that professionals working with families do not always ensure that their communication is effective. In an evaluation of SCRs conducted between 1 April and 30 September 2009, for example, Ofsted (2010c) found that letters, the main means of communicating, are not always suitable for parents with limited education, learning difficulties or an antipathy to formal written communications.

Additionally, the social disadvantage of some parents with limited English is also compounded by a failure by social care staff to help them to communicate effectively (Ofsted, 2010c). Boxes 3 and 4 include further details of the challenges and supporting factors in developing relationships with hard-to-reach children and families.

Box 3 Developing relationships and understanding with parents/carers: what are the challenges and supporting factors?

A number of sources identify the challenges that staff face in engaging with families who are resistant to social care support, or are hard to reach. The report of the Children's Commissioner for England highlighted contexts in which there is likely to be resistance from families to social work support. These include, for example, instances of domestic violence, parental learning disability and poverty. Thoburn (2009; 2010) agreed with this, suggesting that, in families with complex needs, parents may experience one or several of the following:

- isolation and a lack of extended family, community or faith group support
- abusive or emotional rejection as children
- mental illness and/or a learning disability
- being the only parent or extended family member available to share parenting and this may be of a child who is difficult to parent
- personality disorders
- several partners and possibly involved in an abusive relationship
- alcohol or drug addiction, and a lack of acceptance that they must control the habit for the sake of their child's welfare
- aggressive outbursts, a record of violence, possibly including partner violence
- obsessional or controlling personalities, often linked with low self-esteem
- being in care and multiple placements, or 'aged out' of care without a secure base
- fear of stigma or suspicion of statutory services.

The report by the Children's Commissioner for England (2010) found that families who are resistant to social work support have experienced specific barriers.

- They were afraid and uncertain about the remit of social work departments as a result of media portrayal, personal experiences and inherent views.
- They had negative attitudes and understanding of individual social workers. Some families felt unfairly blamed for their circumstances, or that their social worker did not understand poverty. They also felt that social workers sometimes used 'textbook solutions to people's lived experiences' (p.33).
- They had to deal with social workers' inconsistent ways of working; families, such as asylum seekers new to the social work system, found variations in the way that social workers operated.
- Resources and system issues created by the child protection system include social workers being changed (and, conversely, families unable to change to a different social worker); social workers placing an emphasis on

assessments but not following these up with services; and work pressures meaning social workers often arrive late or cancel appointments.

Box 4 Developing relationships and understanding with children and young people: what are the challenges and supporting factors?

Vulnerable children and young people can find it difficult to engage with social workers, placing them at increased risk of harm. They often have these characteristics.

- A premature birth and/or suffering the effects of intrauterine drug and/or alcohol misuse makes them fretful, hard to feed and unresponsive.
- Disabilities or other characteristics make them hard to parent or unrewarding in the eyes of parents who lack self-esteem and confidence.
- They can be singled out for rejection by siblings and/or targeted for abuse.
- They may have returned home from care, and suffer the loss of an attachment figure.
- Teenagers engaged in risk taking or anti-social behaviour (many of whom have suffered from abuse or neglect that has not been either treated or recognised) (Thoburn, 2009; 2010).

Effective practice for statutory and voluntary agencies working with children and young people in relation to safeguarding is set out in *Working Together to Safeguard Children* (DCSF, 2010). The guidance recommends staff:

- develop a direct relationship with the child
- obtain information from the child about his or her situation and needs
- elicit the child's wishes and feelings about their situation now as well as their plans and hopes for the future
- provide children with honest and accurate information about the current situation, as seen by professionals, and future possible actions and interventions
- involve the child in key decision making
- provide appropriate information to the child about his or her right to protection and assistance
- invite children to make recommendations about the services and assistance they need and/or is available to them
- ensure children have access to independent advice and support (for example, through advocates) to be able to express their views and influence decision making.

Source: DCSF (2010, p.33)

2.3.3 The Munro review: next steps

A recurrent theme throughout the Munro's first report related to the impact of problems within the child protection system on professionals' relationships with children and young people, and on understanding their needs. This is expressed in relation to all of the themes identified in this review. Whilst the needs of children and young people will underpin all aspects of the next stages of the review, Munro indicated that the review team will work closely with those involved in the family justice review, commissioned by the Ministry of Justice, to improve the experiences of children and young people involved in care proceedings. It is envisaged that this will lead to a long-term programme of reform to be implemented in the near future.

2.4 Interagency working

2.4.1 What does Laming say about interagency working?

The Laming review recognised that most frontline services are already committed to the principle of interagency working and staff recognise the need to pool information, expertise and resources in order to more effectively safeguard children. However, Laming stated that:

> *It is evident that the challenges of working across organisational boundaries continue to pose barriers in practice, and that cooperative efforts are often the first to suffer when services and individuals are under pressure.*
>
> Laming (2009, p.36)

This section highlights some examples of approaches taken to develop interagency working, and some of the issues and challenges when doing so.

2.4.2 What does the recent literature tell us about interagency teams?

Based on literature review findings, Barlow and Scott (2010) reported that universal services are ideal for assessing families, particularly during pregnancy and the postnatal period. As such, they argued that there is a need to establish trans-disciplinary teams, which place social workers at the heart of teams working in children's centres, schools and perinatal services. In line with Laming's recommendation for multi-agency assessment teams, Stockport NHS, for example, is piloting a new approach whereby a health visitor works in the local authority early intervention team (Stockport NHS, 2010).

A further example of a multi-disciplinary team providing early intervention family support for vulnerable children and families, is in Box 5. The key challenges and supporting features of effective interagency working are set out in Box 6.

Box 5 Interagency working: early intervention family support for vulnerable children and families in Hammersmith and Fulham

In the London Borough of Hammersmith and Fulham, the Early Years and Childcare Service has introduced a Family Support Team (FST). The aim of the team is to improve the safety and well-being of children, and to improve children's outcomes by supporting parent and carer relationships through intensive home-based support. Although started in 2007, the project was expanded in 2009 to include older children aged up to 13. The team has a preventative focus through the provision of early intervention in respect of longer-term health, emotional, education and social problems. The FST is a centralised team of multi-disciplinary professionals to which children's centre staff can refer vulnerable families.

The success of the FST is underpinned by its multi-disciplinary nature, characterised by the co-location of health staff, including professionals from midwifery, clinical psychology, health visiting and primary mental health, working alongside family support workers, social workers, counsellors and mentors, child development advisors, community development officers, integrated working advisors and Connexions staff. The team has also developed links with other agencies to allow for better identification of support needs and coordinated service delivery for families.

Outcomes to date have included the promotion of the FST as a multi-agency route to supporting families; better integrated working with other professionals and resulting ease in workloads; improved information sharing between agencies, resulting in improved early identification of need; evaluation of multi-agency working to reflect on improvements identified through casework reviews and service delivery; and increased links and information sharing with the primary care trust (Centre for Excellence and Outcomes, 2010a)

Box 6 Interagency working: what are the challenges and supporting factors?

Barlow and Scott argued that interagency working should be characterised by shared aims, information, tasks and responsibilities. According to Worrall-Davies and Cottrall, cited in Barlow and Scott (2010), these are the prerequisites for integrated working:

- commitment to joint working at all levels of an organisation
- strategic and operational joint planning and commissioning
- service level agreements and clear interagency protocols cutting across procedural bureaucracy
- clear, jointly agreed aims, objectives and timetables for the service
- delineation of roles and responsibilities for all staff, and clear line-management arrangements
- mutual trust and respect between partner agencies and staff
- recognition of the constraints others are under
- good systems of communication and good relationships at grassroots level
- clear paths for information sharing, including databases
- support, supervision and joint training for staff in new ways of working
- secondments between services and services co-existing in one building
- commitment to evaluation, audit and change
- commitment to consulting with and acting on user/carer views.

Source: Worrall-Davies and Cottrall cited in Barlow and Scott (2010, p.94).

Shared vision and understanding

The findings of Holmes *et al.* (2010) indicated that relationships between professionals are highly variable: this may reflect historical or organisational differences, which in some cases make particular groups difficult to engage (GPs and doctors are considered to be two such groups).

Cooper (2010), reporting on safeguarding at Haringey Council, quoted one social worker: '[...] while we feel multi-agency working has improved, there's still a lack of understanding about each other's roles and responsibilities. We feel that there should be more opportunity to discuss these challenges in training and development' (Cooper, 2010, p.22).

This view was echoed by Barlow and Scott (2010) who, in reporting the findings of Worrall-Davies and Cottrall (2009), said that challenges may arise due to historical conflict between the working practices of individuals and organisations involved in child and family care, as well as competitive relationships between services. They also reported that there can be challenges when particular professionals or disciplines are attached to undertaking particular aspects of assessments and/or therapeutic work, as well as interdisciplinary power struggles and a lack of a common language between different organisations and agencies.

Accountability

Worrall-Davies and Cottrall reported that 'lack of clarity about who takes responsibility in each agency and dysfunction at both operational and strategic levels' could be challenging for effective safeguarding (Worrall-Davies and Cottrall cited in Barlow and Scott, 2010, p.95).

MacLeod *et al.* (2010) reported that where there are strong relationships between local authorities and partner organisations, and a clear understanding of the roles and responsibilities of each, local authorities are able to manage the anxieties of partner agencies. However, it was also found that in some areas 'new tensions have developed and partners have become keener to

"pass on" responsibility for safeguarding activity' (MacLeod *et al*., 2010, p.vii).

France *et al.* (2009) also reported on Laming's recommendation that involvement from education, early years services, health and the police is critical to ensuring that all agencies have a role in safeguarding children, saying that:

Historically there has been a perception that safeguarding children is the responsibility of children's social care, rather than everybody's responsibility. The challenge lies in breaking down organisational barriers to ensure effective cooperation to improve outcomes.

France *et al.* (2009)

Issues relating to joint working between adult and children's services

Jakob and Gumbrell (2009), in their discussion about child neglect and parental learning disability, reported that there can be difficulties arising between children's and adults' social services when both the child and parent have needs to be considered. They reported that historically there have been tensions between adult and children's services in relation to safeguarding children. The authors said:

The focus of children's social workers when working with parents with learning disabilities can often be on the deficits that a parent has in meeting a child's needs, rather than a holistic approach.

Jakob and Gumbrell (2009, p.111)

By contrast, adults' social workers often have more limited awareness of the issues surrounding the safeguarding of children when working with the adult in question. Jakob and Gumbrell (2009) argued that this division begins at training level when professionals are developing their expertise, and the problem is further entrenched by the position of these teams within the local authority: children's services are aligned with education, whilst adult services are aligned with health.

2.4.3 What does the recent literature tell us about interagency communication and information sharing?

Holmes *et al.* (2010) suggested that information sharing between agencies is continuing to develop and improve, and they considered the **Common Assessment Framework** (CAF) to be 'important in terms of improving interagency working and ensuring that cases receive an appropriate service response' (Holmes *et al*., 2010, p.42). However, the same study also suggested that there is significant capacity to further improve information-sharing arrangements. They found that 'local authorities reported reluctance by other professionals and agencies to act as the lead professional in cases' and that 'social work professionals perceived reluctance by other agencies to manage risk and an inclination to transfer responsibility to children's social care' (Holmes *et al*., 2010, p.43).

Further issues in relation to interagency communication were identified by Ofsted (2010a) in their survey of **social work practitioners** who found that less than half of the respondents agree that communication and information sharing is effective both within their local authority and with other organisations contributing to safeguarding. In an equivalent survey of **third-sector organisations**, fewer than half of respondents report that there is effective partnership working between the local authority and the third sector.

Within the health sector, the report of the Care Quality Commission (2009) on arrangements in the NHS for safeguarding children found that NHS trusts are usually represented at meetings of their local safeguarding children boards, and, in most cases, they have information-sharing protocols in place, both within and between organisations. However, just over a third of applicable acute trusts do not have a policy in place for joint working between maternity services and social services (Care Quality Commission, 2009).

Research by Forge (2010) aimed to elicit the perceptions of the diverse staff sharing the information in emergency department (ED) child records. These include nurses, doctors and health visitors. Children with the greatest needs are a particular issue for EDs, and the research found that ED records are a good tool for communicating these needs between staff. However, the research also highlighted the fact that the

records must incorporate a comprehensive history, since the information could alert a clinician to possible risk factors that are likely to affect the welfare of a child. The challenges of sharing written ED records with other agencies are set out in Box 7.

Box 7 Interagency communication: what are the challenges and supporting factors?

Forge (2010) found that in the case of EDs, written documentation can be unclear, insufficiently focused on the child, illegible and incomplete. Risk factors are not always recognised and existing written records may not provide a format that enables staff to record information comprehensively. Shortcomings in documentation may create multiple difficulties for another agency or professional to which the child is referred. Inaccurate accounts may lead to the failure to safeguard a child. The staff in Forge's research were concerned that existing records do not provide a format to enable staff to record comprehensive information.

For schools it is vital that safeguarding information (as well as general information) about pupils is quickly and accurately shared (both between schools and between schools and other agencies). Bandele (2009) suggested that at each stage of transition, or when a pupil moves school, provision is made for a comprehensive handover of information and records that highlight vulnerability or risk. As a minimum, there should be a face-to-face meeting between relevant child protection or safeguarding officers for all children within a local authority area for whom a child protection record exists. If a child moves out of the local authority area, these records should be sent recorded delivery to the named child protection or safeguarding officer of the receiving local authority, preferably with a follow-up telephone call to ensure receipt and to clarify any questions raised.

An example of recent practice development is in Sheffield, where some schools are using an adapted version of the Government's Pre-CAF checklist for all their transitioning children to identify vulnerability on intake, as well as to pass information to receiving schools and services (Fish, 2009). Improving practice was also highlighted in Lewisham where it was noted that in the last year communication between schools and children's social care has been much improved. Clear information is now given to all schools about the structure of teams in children's social care, and school safeguarding leads have built up knowledge and relationships with social care practitioners so they know who to talk to and feel confident about overcoming issues relating to differing views or expectations (Lewisham, 2010).

In their research into how **LSCBs** are operating, France *et al.*, (2009) found that there is great variety in the methods by which LSCBs communicated information, policies and protocols to relevant agencies. Almost half of LSCBs see board members as having responsibility for communicating policies and procedures to their own agency, and interviews with chairs and business managers indicate that individual board members are responsible for this. However, they are less certain about how far this is happening and whether information is reaching the appropriate staff (France *et al.*, 2009). One LSCB has overcome this problem by developing a **multi-agency forum** where information can be distributed to frontline staff. Other LSCBs report that policies and procedures are communicated using mechanisms such as web pages, training and regular newsletters.

France *et al.* (2009) also reported that some LSCBs have experienced difficulties in establishing networks with other agencies, particularly relating to the health sector (specifically GPs). Links with state schools are perceived as being relatively strong although less well developed in the case of independent schools. Links with the third sector are also strong, although some reported that there 'remain[s] a challenge understanding and accessing the views of smaller organisations' (p.48). The majority of LSCBs engaged in France *et al.*'s (2009) research reported that they have a positive relationship with neighbouring LSCBs (either formally or informally). These links have been particularly beneficial in developing policies and procedures, and in sharing learning and information. Box 8 has examples of developments in interagency communication and information sharing in two local authorities.

Box 8 Developments in interagency communication and information sharing

Interagency working: early notification of pregnancy in Lancashire

Lancashire Council has established a process for early notification of pregnancy that aims to protect children living in families where they are at risk of abuse, harm or neglect. The early notification process allows midwives to notify children's centres of a pregnancy by completing a form with the mother giving the children's centre permission to contact her.

The early notification process has resulted in a consistent approach to involving children's centres across Lancashire. There has been an increase in communication between the midwifery, children's centres and health visiting services. There are also more opportunities for information sharing to best meet the needs of the family. This partnership approach has also allowed midwives to concentrate more fully on the clinical aspects of their role during the antenatal period, allowing children's centres to provide additional social support to mother and baby.

The commitment of service heads to the early notification process has resulted in better communication between NHS services and the Sure Start early years and childcare service. Centre staff have been involved in direct negotiations to move existing community health services into children's centres as a result of the partnership that has developed between the organisations.

Key features for effectiveness in the early notification process include good communication and a joint working ethic between partner agencies, the willingness to share information, and trust between agencies that effective and appropriate work is being carried out where necessary (Centre for Excellence and Outcomes, 2010b).

2.4.4 The Munro review: next steps

Munro (2010) drew attention to the critical importance of professionals in universal services (for example, education services, accident and emergency departments) gaining a better understanding of the needs of young people in relation to child protection issues and becoming more adept in recognising and responding to child protection concerns. However, Munro emphasised that this must be coupled with a clear understanding amongst universal services providers of the role and remit of social workers in supporting children and young people to ensure that this does not result in excessive referrals.

The review intends to explore the means by which the professional judgements made by referrers in universal services and other agencies could be better managed. This may have multifaceted benefits as a result of improved working relationships and a deeper sense of shared understanding; reduced demand on social work resources due to a more informed and considered referral process; and reduced distress for parents and carers as a result of fewer unnecessary interventions and more thorough early intervention support.

2.5 Quality assurance and monitoring

2.5.1 What does Laming say about quality assurance and monitoring?

The Laming review identified local authorities' performance management as a central aspect of leadership and accountability. The review stated that collaboration is required to develop systems for managing performance that:

> *[...] drives improvement in the quality of services designed to safeguard and promote the welfare of children and enable them to ensure they are meeting their responsibilities for keeping children safe.*
>
> Laming (2009, p.15)

Laming also said local authorities' lead members should be proactive in scrutinising a range of management information and ensuring that quality assurance systems are appropriate and effective.

2.5.2 What does the recent literature tell us about the tools used for quality assurance and monitoring?

According to Fish:

> *Assuring the quality of both professional practice and organisational processes and structures depends on robust internal and cross-agency audit and quality assurance systems.*
>
> (2009, p.4)

Fish also said that increased significance is being given to the practice of local auditing. Multi-agency audits in particular (including case-file audits) are used as means of ascertaining and evaluating the realities of safeguarding practitioners' day-to-day work and challenging the underlying issues about the quality of frontline practice. Whilst Fish concluded that there does not appear to be a great deal of literature about local auditing since the Laming review, there are local examples where audit tools have been used effectively. See Box 9 for details.

Box 9 Quality assurance and monitoring: local examples of audit tools

Welsh LSCB self-assessment and improvement tool

This evaluates progress, strengths and weaknesses in areas that are judged to be crucial for achieving effective cooperation at strategic and practice levels in order to both safeguard and achieve better outcomes for children. Elements include: a shared strategic vision, effective governance arrangements and systems. Using this tool, LSCB members rate their performance in each of these domains in relation to the LSCBs' statutory duties and then propose actions to address areas of weakness.

Sheffield safeguarding evaluation programme

Sheffield LSCB has developed a safeguarding evaluation programme to consider how effectively organisations are embedding safeguarding practices and integrated working into the delivery of their services. A variety of measures have been employed for the evaluation.

- **Self-audit**: developed to capture information on safeguarding practices among local organisations. It covers safeguarding policies and procedures; information sharing; recording incidents of concern; recruitment of staff and volunteers; training; and safer employment.
- **Questionnaires for professionals, volunteers and members of the public**: questionnaires are anonymous and ask about experiences of safeguarding; early intervention and integrated working; whether or not they feel confident responding to issues of concern; and what they perceive to be local priorities.
- **Case-file review**: via a sample of cases being reviewed by the LSCB for evidence of good practice in safeguarding and early intervention.
- **Consultation with people who use services**: asking parents and carers if they are prepared to talk to someone from the safeguarding children board about their experience of the services they received.

Source: Fish (2009)

2.5.3 What does the recent literature tell us about the application of quality assurance procedures?

The application of quality assurance procedures across and within agencies appears to be variable. The Care Quality Commission (2009) found, for example, that within NHS trusts a greater proportion of designated nurses meet with their board at least once every two months, compared to designated doctors. This study also found that the frequency with which boards monitor compliance with their safeguarding responsibilities varies, but this usually takes place on an annual basis or when they are notified about serious incidents. Other findings highlight omissions within the processes covered by child protection policies, and express specific concern about the absence in many NHS trusts of follow-up procedures for children who miss outpatient appointments (Care Quality Commission, 2009).

Evidence of recent practice development in relation to quality assurance at the local level was also identified. For example, following the Laming review, in Barking and Dagenham, NHS London commissioned Safeguarding Improvement Team (SIT) peer review visits to support NHS services in their work to safeguard children. Activity is audited through a series of discussions and interviews, to look at what is happening in practice, and to offer an outside perspective on any improvements that might be made (Cullum, 2010). In addition, in Haringey, a safeguarding panel has been established to oversee complex cases and to ensure that case plans are supported. This panel provides an additional quality check on casework and is said to be valued by staff (Cooper, 2010).

2.5.4 What does the recent literature tell us about the role of performance indicators?

The role of current performance indicators was highlighted by Laming as a specific shortcoming due to their focus on processes and timescales rather than quality (Laming, 2009). Laming argued that performance indicators are 'not helpful in creating shared safeguarding priorities amongst statutory partners, are unclear in their impact upon positive outcomes for children and young people, and do not drive improved services' (Laming, 2009, p.15).

Fish (2009) reported that following the publication of the Laming review, many local authorities have put plans in place to adapt their systems for measuring performance in order to monitor the quality of safeguarding practice. Responses from the sector, however, have been rather more defensive of the use of performance indicators as a tool for ensuring the accountability of local authorities. Fish (2009) reported that organisations such as the LG Association, the Association of Directors of Children's Services (ADCS) and Ofsted indicate that, although performance indicators should not be used exclusively as a tool for measuring quality, they remain a 'necessary measure of the quality of decision-making and organisational support' (Fish, 2009, p.11).

2.5.5 The Munro review: next steps

Munro highlighted the importance of ensuring quality assurance and monitoring systems (including performance management and inspection processes) are designed to support children's social care teams' core aim to deliver high-quality services for children. Therefore, the review aims to consider:

> *How to create a system characterised by good local management information, with focused and meaningful national data, combined with regular feedback from children, young people, families, staff and partners.*
>
> Munro (2010, p.42)

This will include exploring the distinction between performance indicators, as they relate to the quality of services provided by children's social care teams, and outcomes indicators as they relate to children and young people's experiences of child protection. The review will consider 'how the focus on performance indicators and targets could be modified so that a focus on outcomes for children is the central point of accountability in children's services' (Munro, 2010, p.42). Munro will also work with Ofsted, service leaders and other professionals to consider inspection system reform so that local authorities are supported, rather than stigmatised, improvement needs are identified, and local authorities praised and rewarded for excellent practice.

2.6 SCRs

The purpose of an SCR is to establish whether there are lessons to be learned from a specific child protection case for professionals and organisations that have worked together to safeguard and promote the welfare of children. SCRs are, therefore, critically important to the ongoing protection of children.

2.6.1 What does Laming say about SCRs?

Laming identified SCRs as 'an important tool for learning lessons from the death of, or a serious incident involving, a child' (2009 p.63). Although the conclusion is that SCRs are now generally well established and have, in principle, support from all services, Laming acknowledged that 'the purpose and processes of SCRs

can be further developed to strengthen their impact on keeping children safe from harm' (Laming, 2009, p.63).

2.6.2 What does the recent literature tell us about conducting serious case reviews?

Considering the outcomes of their evaluation of SCRs (carried out and completed between 1 April 2008 and 31 March 2009), Ofsted found both that SCRs are generally being carried out more speedily, and that LSCBs are becoming more rigorous in their scrutiny of individual management reviews and overview reports (Ofsted, 2009).

The Laming review also highlighted the need for learning from SCRs 'to be shared quickly so that lessons are learned across different areas and agencies' (2009, p.69). An indication that such learning is being communicated more effectively since the Laming review could be drawn from the Ofsted survey of social work practitioners which found that a half of respondents feel informed of issues arising from SCRs (Ofsted, 2010a).

The Social Care Institute for Excellence (Scie) is trialling a model for conducting SCRs (which it developed) and to date has received positive feedback from pilot schemes in Wirral, Salford and Lancashire:

> *The Scie model involves getting closer to the staff, across different agencies, and bringing them along with the discourse of the review rather than them needing to feel that the SCR is totally top-down [...]. Practitioners involved in the case are actively involved in this process. Rather than starting with individual management reviews, senior managers from across agencies work together to analyse both single agency working and also, critically, the interplay between agencies.*
>
> Garboden (2010b, para. 10–12)

Box 10 has examples of SCR reviews.

Box 10 Practice examples: SCRs

Manchester was the first council to produce an SCR rated outstanding by Ofsted. According to the independent chair of the LSCB, critical to success was retraining the writers of internal management reviews and retraining senior managers in each agency to quality assure the reviews. SCRs have also become more focused on the positive, which the chair of the LSCB believes is more conducive to learning in the sector. He noted that 'with most SCRs, you tend to read a catalogue of perceived and actual failures [...]. What we try to do is blend that with an emphasis on what works and how we can be doing more to take that positive action forward' (Garboden, 2010b, para. 24).

In Medway, practice reviews on cases that do not meet the SCR threshold are now routinely undertaken so that the opportunity can be used to learn lessons. This includes a recent practice review of a child's death on a school trip (Collinson, 2009).

The Care Quality Commission (2009) found that, within the health sector, two-thirds of reviews of individual cases are completed and signed off within one to three months, and, in most cases, action plans and recommendations arising from serious case reviews are given to the responsible service managers. However, almost one in five took more than four months, suggesting 'a breach of the target set out in national guidance for the local safeguarding children board to complete the composite serious case review report within four months' (Care Quality Commission, 2009). The Care Quality Commission also found that in some cases, PCTs do not play a role in coordinating local healthcare organisations' contributions to SCRs, and in some instances had not reported the SCR to their strategic health authority. Box 11 identifies challenges and supporting factors for effective SCRs.

Box 11 SCRs: challenges and supporting features

Ofsted (2010c), reporting on the findings of their analysis of 85 SCRs conducted between 1 April and 30 September 2009, identified challenges in a number of service areas.

- **Health**: there are instances where health practitioners have noted the signs and symptoms of potential abuse, but have not communicated these to other professionals or agencies. Generally, staff providing health services for children have received appropriate training. However, in some cases, a lack of managerial overseeing means that health practitioners went unchallenged and concerns are not identified. There are instances of communication breakdowns between professionals: 'Those making the referral assumed that the service was being provided and, in turn, the provider assumed that, if the child or the family did not attend the given appointment, the service was not needed' (p.12).

- **Education**: the use of the CAF is not always embedded amongst education professionals. Training, although given, is not always followed. Where SCR panels need to examine the childhood histories of teenage parents, they are often hindered due to school records being unavailable as they have been destroyed in accordance with local record retention policies.

- **Universal services**: 'Universal services such as schools, Connexions and youth services were not working collaboratively. They tended to focus on the presenting behaviour rather than taking a wider overview, and they struggled to meet the young people's needs. The majority of these young people were not seen as being at risk of harm to themselves. In some cases there was a lack of communication and joined-up working between universal services and those such as child and adolescent mental health services' (Ofsted, 2010c).

Ofsted (2009) reported several factors that have supported the improvement of SCRs.

- Direct feedback to LSCBs by Her Majesty's Inspectors (HMI) as part of the evaluation process resulted in improved depth of learning, as evidenced by improvements in subsequent reviews.

- Increased requirements on LSCBs announced by the Secretary of State after the Baby Peter case have ensured that the SCR process and subsequent depth of learning are more effective.

- Strengthened processes for conducting serious case reviews have lead to more robust quality assurance, recommendations and action plans.

SCRs where disability is a factor: lessons for future practice

Ofsted (2009) identified lessons for future practice for SCRs involving disabled children. Ofsted made a number of points.

- Disabled children, and young carers who may be caring for a disabled parent are not always receiving the assessments of needs to which they are entitled and as a consequence do not receive services which meet their needs.

- The focus of support for parents of disabled children needs to be tailored to meet the individual needs of the child and provide the parenting skills that enable the adult to address her or his overall care, safety and well-being.

- Good practice in safeguarding children is seen where there are robust links between child protection workers and disability workers and where there is sufficient training to increase the understanding and ability of disability workers to take into account both disability and child protection issues.

- Cases involving disabled children benefit from involving more experienced staff when there

are dual issues of child protection and complex disabilities involved.

- Voluntary organisations often play a valuable part in supporting children and families. It is important that staff in these agencies have a good understanding of, and confidence in addressing, child protection responsibilities.

- Clear processes for communicating and sharing information across different remits within children's services, and across adult and children's services, are vital when there are child protection concerns in families in which the children have caring responsibilities for disabled parents.

SCRs of children who are looked after: lessons for future practice

Similarly, Ofsted (2009) identified lessons for future practice for SCRs involving children who are looked after.

- It is important to listen to and work directly with children to understand their perceptions of their experiences, particularly when they present as unhappy or unwell.

- Looked-after services need to be planned and managed as part of a continuum of local authority services rather than being considered separately.

- Sufficient staff with the appropriate expertise need to be assigned to provide and support services for looked-after children.

- The requirements of legislation and regulations in relation to the assessment, approval, matching and support for foster carers and adopters need to be followed, despite the challenges of finding placements for some children.

- Managing the overseeing of staff needs to be effective so that disputes between professionals can be resolved. There must be a clear process by which any disputes can be escalated through the management line.

- All agencies should consistently fulfil their responsibilities, including completing personal education plans and holistic health assessments, and rigorous responses by the police and other agencies when children are missing from care.

2.6.3 The Munro review: next steps

Munro suggested that there is considerable progress yet to be made in supporting SCRs to reflect a learning culture based upon an understanding of *why* circumstances have arisen and a keenness to ensure that this learning is carried forward into other child protection activities.

The review will, therefore, be considering how SCRs can be used as part of a 'wider context of learning that reviews practice at every stage of a child's journey through the child protection system' (Munro, 2010, p.42). This will include exploring how local systems can become more reflective and facilitate in-depth, inter-professional learning about child protection that supports SCRs to become more outcomes focused.

The review will also consider how LSCBs can contribute to the strategic leadership of SCRs, and how they can effectively fulfil their role in leading practice-based learning. This will include considering 'their strengthened contribution to multi-agency learning and development and their strategic leadership locally in relation to the quality and impact of child protection services' (Munro, 2010, p.42).

2.7 Referrals and assessment

2.7.1 What does Laming say about referrals and assessment?

Laming recommended that senior service managers, including directors of children's services, chief executives of PCTs and police area commanders, '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' (Laming 2009, p.84).

2.7.2 The development of referrals and assessments

There is some evidence of changes in referral and assessment practice. For example, in their report calculating the cost and capacity implications for local authorities implementing the Laming review (2009) recommendations, Holmes *et al.* (2010) found that the majority of local authorities in their sample had made changes to their referral, assessment and supervision processes. These changes included greater levels of managerial overseeing of cases, strengthened audit systems, and developments or changes to supervision policies.

A specific example of such changes at a local level is evident in Haringey Borough Council, which has restructured its management and teams. According to one social worker this has 'created more efficient services and the way crisis referrals are processed is safer and leads to quicker assessment of needs and safer working practices' (Cooper, 2010, p 22). Cooper (2010) also reported that positive changes in Haringey have come about due to an effective initial screening system for referrals to children social care services. Similarly, the introduction of threshold criteria, introduced in October 2009, is starting to see a reduction in the number of referrals that require social work intervention.

However, in an evaluation of SCRs conducted between 1 April and 30 September 2009, Ofsted found that:

> *Referrals, primarily by health and social care professionals, were not always followed up sufficiently rigorously. Assumptions were made that families and individual children were receiving services that would meet their assessed needs, such as pre-school day care, services relating to domestic abuse, mental health and family therapy services, when these were not happening.*
>
> Ofsted (2010c, p.14)

Box 12 outlines further challenges relating to safeguarding referrals and assessments.

Box 12 Referrals and assessment: challenges and supporting factors

Number of referrals

MacLeod *et al.* (2010) reported that following the Baby Peter case being made public in November 2008, local authorities experienced a significant increase in the number of Section 31 applications[5]. They also said many local authorities reported an increase in the tendency of partner agencies to make referrals to children's social care. This view is shared by Garboden (2009) of the year following the case being made public.

Threshold for assessment

Holmes *et al.* (2010) expressed concerns that a great deal of time within referral teams is spent signposting to other agencies and responding to initial contacts that are below the threshold for statutory intervention. Fluctuating demand for the resources within referral teams can also create additional pressure for teams. They said 'the absence of early intervention and preventative services may lead to the escalation of need in the future, and therefore have longer-term cost implications (Holmes *et al.*, 2010, p.41). This view is shared by MacLeod *et al.* (2010), who also found that a number of local authorities experienced a growth in the number of referrals that did not meet the threshold for statutory intervention.

Demand for placements

MacLeod *et al.* (2010) found that social care teams had experienced a significant increase in the demand for placements following the Baby Peter case, which had in some circumstances led to greater reliance on independent fostering agencies. Garboden (2009) echoed this concern: 'When the system is under pressure it's easy to breathe a sigh of relief when a placement is found for a child and then move onto the next task. People don't necessarily make a long-term plan for that child because of their heavy workload' (Garboden, 2009, p.18).

Prioritisation of some groups to the detriment of others

There is concern that as a result of Laming, attention has been focused on cases similar to that of Baby Peter, thus inadvertently diverting attention away from other groups of vulnerable children. In particular, Garboden (2010a) argued that there are major concerns about a lack of focus on children and young people who have been sexually abused and, to a lesser extent, disabled children, teenagers at risk of sexual exploitation and children of parents with mental illness. This lack of focus means that fewer preventive and early intervention services exist (Garboden, 2010a).

2.7.3 The Munro review: next steps

The challenges identified in this NFER review are similar to those identified by Munro in relation to the growing numbers of referrals and assessments to children's social services. Munro also highlighted examples of local innovation in response to this. For example, there are systems enabling experienced social workers to discuss potential referrals with referrers before a referral is made to ascertain whether it is necessary and appropriate; there are also systems enabling social workers to form multi-agency teams with potential referring agencies in order to improve the flow of communication. The review will therefore be working with local authorities to explore the effectiveness of such innovative strategies.

The review will also consider 'the assessment framework and process and the potential for a more flexible child-centred approach' (Munro, 2010, p.42). As discussed in section 2.1.5, this will include working closely with the SWRB to further develop the training and development aspects of assessment.

Notes

3 Level 1 relates to the National Qualifications Framework. No previous qualifications or prior knowledge of the subject is needed in order to study a level 1 qualification. Level 1 qualifications include any qualification with no formal entry requirements e.g. Foundation GNVQ, NVQ 1 and Skills For Life.

4 Haringey Teaching Primary Care Trust, North Middlesex University Hospital NHS Trust, The Whittington Hospital NHS Trust and the Great Ormond Street Hospital for Children NHS Trust.)

5 Under Section 31 of the Children Act 1989, local authorities can apply for a care or supervision order for children believed to be suffering, or are likely to suffer, significant harm.

3 Conclusion

Concluding comments: evidence of changes and improvements in safeguarding practice since the Laming review

A reasonable amount of evidence of changes and improvements in safeguarding practice, since the Laming review in March 2009 has been identified in this review. From the literature identified and reviewed, there is evidence to suggest that work to develop the safeguarding of children is being implemented across a range of service areas covering a wide spectrum of practice. Evidence of developments in practice was specifically found in relation to training and professional development; capacity and recruitment of professionals; improvements in relationships and understanding; interagency working; quality assurance and monitoring, SCRs, and referrals and assessments.

However, given the relatively short amount of time since the Laming review (approximately 18 months), it is perhaps unsurprising that published literature setting out specific developments in safeguarding practice, as a result of Laming's recommendations, is somewhat limited. Where examples were provided, many referred to developments in Haringey, which is perhaps understandable given the close scrutiny of this authority since the Baby Peter case. A further issue is that it is very likely that many of the shifts in local authority practice are documented in internal (unpublished) plans and procedures, while others may be less tangible, such as cultural changes, which are more difficult to record. Similarly, any formal evaluation of changes in safeguarding practice, at a local level, is likely to be currently ongoing and yet to be published.

Concluding comments: evidence of challenges and supporting factors in making improvements in safeguarding practice

The evidence reviewed highlights the many challenges that remain in implementing Laming's recommendations, not least in the areas of workforce development, capacity, and interagency working.

Along with the LG Association's Five Point Plan, the findings set out in this review will be used to inform the research framework for the next study in the safeguarding children series. This next study (to be conducted by the NFER for the LG Association) aims to evidence key learning from five English local authorities that have improved their performance in the area of safeguarding children according to recent inspections. This work is due to be published in Spring 2011.

References

Atkinson, A. (2010). *Safeguarding Post-Laming: Initial Scoping Study*. Slough: NFER [online]. Available: http://www.lga.gov.uk/lga/aio/10626631 [accessed 12 November 2010].

Bandele, F. (2009). 'The contribution of schools to safeguarding children.' In: Hughes, L. and Owen, H. (Eds) *Good Practice in Safeguarding Children: Working Effectively in Child Protection*. London: Jessica Kingsley Publishers.

Barlow, J. and Scott, J. (2010). *Safeguarding in the 21st Century – Where to Now?* Dartington: Research in Practice.

Burton, S. (2009). *The Oversight and Review of Cases in the Light of Changing Circumstances and New Information: How Do People Respond to New (and Challenging) Information?* London: C4EO [online]. Available: http://www.c4eo.org.uk/themes/safeguarding/files/safeguarding_briefing_3.pdf [accessed 8 September 2010].

Care Quality Commission (2009). *Safeguarding Children: a Review of Arrangements in the NHS for Safeguarding Children*. London: CQC [online]. Available: http://www.cqc.org.uk/_db/_documents/Safeguarding_Children_200907153039.pdf [accessed 8 September 2010].

Care Quality Commission (2010). *Involvement and Action Taken by Health Bodies in Relation to the Case of Baby Peter Connelly: Progress Against the Recommendations of our Intervention Report*. London: CQC [online]. Available: http://www.cqc.org.uk/_db/_documents/20100518_Final_Baby_P_Progress_Report_201006083850.pdf [accessed 8 September 2010].

Centre for Excellence and Outcomes (2010a). *Promising Practice Details: a Multi-disciplinary Approach to Early Intervention Family Support for Vulnerable Children and Families, Hammersmith and Fulham*. London: C4EO. [online]. Available: http://www.c4eo.org.uk/themes/earlyintervention/vlpdetails.aspx?lpeid=215 [accessed 8 September 2010].

Centre for Excellence and Outcomes (2010b). *Validated Local Practice: Early Notification of Pregnancy, Lancashire*. London: C4EO. [online]. Available: http://www.c4eo.org.uk/casestudies/lancashire/ [accessed 8 September 2010].

Children's Commissioner for England (2010). *The Children's Commissioner for England's Report on: Family Perspectives on Safeguarding and on Relationships with Children's Services*. London: Children's Commissioner for England [online]. Available: http://www.childrenscommissioner.gov.uk/content/publications/content_405 [accessed 8 September 2010].

Collinson, R. (2009). *Medway: Director's Letter Autumn 2009* [online]. Available: www.medway.gov.uk/directors_letter_autumn_2009.doc [accessed 7 October 2010].

Community Care (2010). 'Solutions in supervision' [online]. Available: http://www.communitycare.co.uk/Articles/2010/04/09/114251/pioneers-in-better-supervision-for-social-workers.htm [accessed 7 October 2010].

Cooper, J. (2010). 'Back on track after Baby P.' *Community Care*, **1808** (4 Mar), 20–22.

Cullum, R. (2010). *Agenda and Minutes: Barking and Dagenham Partnership – Children's Trust* [online]. Available: http://moderngov.barking-dagenham.gov.uk/ieListDocuments.aspx?MId=5213 [accessed 7 October 2010].

DCSF (2009). *The Protection of Children In England: A Progress Report*. Norwich: The Stationery Office [online]. Available: http://publications.everychildmatters.gov.uk/eOrderingDownload/HC-330.pdf [accessed 8 September 2010].

DCSF (2010). *Working Together to Safeguard Children: A Guide to Inter-agency Working to Safeguard and Promote the Welfare of Children*. London: The Stationery Office [online]. Available:http://publications.education.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DCSF-00305-2010 [accessed 7 October 2010].

Fish, S. (2009). *What are the Key Questions for Audit of Child Protection Systems and Decision-making? London: C4EO*. [online]. Available: http://www.c4eo.org.uk/themes/safeguarding/files/safeguarding_briefing_2.pdf [accessed 8 September 2010].

Forge, J. (2010). 'Safeguarding children by means of information sharing.' *Community Practitioner*, **83** (1),16–19.

France, A., Munro, E.R., Meredith, J., Manful, E. and Beckhelling, J. (2009). *Effectiveness of the New Local Safeguarding Children Boards in England: Interim Report* (Research Report DCSF-RR126) [online]. Available: http://www.education.gov.uk/research/data/uploadfiles/DCSF-RR126.pdf [accessed 8 September 2010].

Garboden, M. (2009). 'Baby P: one year on.' *Community Care*, **1795** (12 Nov),18–19.

Garboden, M. (2010a). 'Left behind by Laming.' *Community Care*, **1812** (1 Apr),18–19.

Garboden, M. (2010b). 'What makes for a successful serious case review?' *Community Care*. [online]. Available: http://www.communitycare.co.uk/Articles/2010/08/04/115026/what-makes-for-a-successful-serious-case-review.htm [accessed 8 September 2010].

HM Government (2009). *Government Response to the Social Work Task Force*. London: HM Government [online].Available: http://publications.education.gov.uk/eOrderingDownload/SWTF-GovResponse.pdf [accessed 8 September 2010].

Holmes, L., Munro, E.R. and Soper, J. (2010). *Calculating the Cost and Capacity Implications for Local Authorities Implementing the Laming (2009) Recommendations*. London: LGA [online]. Available: http://www.lga.gov.uk/lga/aio/9387423 [accessed 8 September 2010].

Jakob, R. and Gumbrell, G. (2009). 'Neglect and parental learning disability.' In: Holmes, L. and Owen, H. (Eds). *Good Practice in Safeguarding Children: Working Effectively in Child Protection*. London: Jessica Kingsley Publishers.

Laming, H. (2009). *The Protection of Children in England: a Progress Report (HC 330)*. London: The Stationery Office [online]. Available: http://publications.dcsf.gov.uk/eOrderingDownload/HC-330.pdf [accessed 8 September 2010].

Lewisham Council (2010). *Safeguarding: Information Sharing for Child protection: a Review by the Children and Young People Select Committee Lewisham: Communications Unit* [online]. Available: www.lewisham.gov.uk/.../SafeguardingInformationSharingForChildProtection.pdf [accessed 7 October 2010].

Ly, K. (2009). 'Frontline pressures after Baby P.' *Community Practitioner*, **82** (6),12–13.

MacLeod, S., Hart, R., Jeffes, J. and Wilkin, A. (2010). *The Impact of the Baby Peter Case on Applications for Care Orders* (LGA Research Report). Slough: NFER.

Morris, S. (2009). *The Hertfordshire Academy for Newly Qualified Social Workers. Hertfordshire County Council* [online]. Available: www.hertsdirect.org/.../091118_02_Hertfordshire_Academy_for_Newly_Qualified_Social_Workers.doc [accessed 7 October 2010].

Munro, E. (2010). *The Munro Review of Child Protection, Part One: a Systems Analysis* [online]. Available: http://www.education.gov.uk/munroreview/downloads/TheMunroReviewofChildProtection-Part%20one.pdf [accessed 9 November 2010].

Ofsted (2009). *Learning Lessons from Serious Case Reviews: Year 2*. Manchester: Ofsted [online]. Available: http://www.ofsted.gov.uk/Ofsted-home/Publications-and-research/Browse-all-by/Documents-by-type/Thematic-reports/Learning-lessons-from-serious-case-reviews-year-2 [accessed 8 September 2010].

Ofsted (2010a). *Safeguarding and Looked After Children. National Results for Children's Social Work Practitioners Survey 2010 (NAT '10)*. Manchester: Ofsted [online]. Available: http://www.ofsted.gov.uk/Ofsted-home/Publications-and-research/Browse-all-by/Documents-by-type/Thematic-reports/Safeguarding-and-looked-after-children-national-results-for-children-s-social-work-practitioners-survey-2010 [accessed 8 September 2010].

Ofsted (2010b). *Safeguarding and Looked After Children. National Results for Third Sector Organisations Survey 2010 (NAT '10)* Manchester: Ofsted [online]. Available: http://www.ofsted.gov.uk/Ofsted-home/Publications-and-research/Browse-all-by/Documents-by-type/Thematic-reports/Safeguarding-and-looked-after-children-national-third-sector-organisation-survey-2010 [assessed 8 September 2010].

Ofsted (2010c). *Learning Lessons from Serious Case Reviews: Interim Report 2009–10* Manchester: Ofsted [online]. Available: http://www.ofsted.gov.uk/Ofsted-home/Publications-and-research/Browse-all-by/Documents-by-type/Statistics/Other-statistics/Learning-lessons-from-serious-case-reviews-interim-report-2009-10 [accessed 8 September 2010].

Stockport NHS (2010). *Safeguarding Children Annual Report*. [online]. Available: www.stockport-pct.nhs.uk/BoardPapers/.../Item14%20Safeguarding%20Annual%20Report%20June%202010.pdf [accessed 7 October 2010].

Thoburn, J. (2009). *Effective Interventions for Complex Families Where There are Concerns About, or Evidence of, a Child Suffering Significant Harm* [online]. Available: http://www.c4eo.org.uk/themes/safeguarding/files/safeguarding_briefing_1.pdf [accessed 8 September 2010].

Thoburn, J. (2010). *Towards Knowledge-based Practice in Complex Child Protection Cases: a Research-based Expert Briefing* [online]. Available:http://pierprofessional.metapress.com/content/2564550m1u666574/fulltext.pdf [accessed 8 September 2010].

Waterman, C. (2009). Making progress after Laming Mark II. Education Journal, pp.25–28.

Appendix: search strategy

A1 Strand 1: search of relevant research databases

Database searches were conducted by the NFER Library using a similar strategy to that used in the scoping study by Atkinson (2010). The databases searched were:

Applied Social Sciences Index and Abstracts (ASSIA)

British Education Index (BEI)

British Education Index Free Collections

ChildData

Criminal Justice Abstracts

Social Care Online

Social Policy and Practice.

In addition to the search terms used in the initial scoping study (for example, Laming, safeguarding, child protection and Baby Peter), the search strategy for this review included the terms: social work, social care and social workers.

A2 Strand 2: search of relevant websites

In order to identify additional reports and published and unpublished documents relevant to the review, a search of a selection of local authority websites and relevant national organisation and government websites were conducted. Websites included:

Department for Education (DfE)

Local Government Association (LGA)

Association of Directors of Children's Services (ADCS)

Ofsted

National Society for the Prevention of Cruelty to Children (NSPCC)

Barnardo's

Children and Family Court Advisory and Support Service (CAFCASS)

Independent Safeguarding Authority (ISA)

Social Work Task Force

Children and Young People Now

Children's Workforce Development Council (CWDC)

Research In Practice

Local Government Chronicle

British Association of Social Workers (BASW)

General Social Care Council (GSCC)

Centre for Excellence and Outcomes (C4EO)

Community Care

Social Care Institute for Excellence (SCIE)

British Association for Adoption and Fostering (BAAF)

Audit Commission

Care Quality Commission

Healthcare Commission

Department of Health (DoH)

National Institute for Clinical Excellence (NICE)

and a selection of local authority websites.

A3 Strand 3: requests to key contacts

The research team also sent a direct request to a small number of key contacts (for example, LG Association and Centre for Excellence and Outcomes) to identify potential unpublished (or published) documents and literature that are not identified by the searches.

A4 Identification of relevant sources

Having received the results of the searches in all three strands outlined above, they were combined with the search results from the scoping study (Atkinson, 2010). The research team identified possible sources to be included in the review using a range of criteria, including:

- evidence of approaches taken to develop safeguarding practice and their impact
- evidence on the levers and challenges of effective safeguarding practice

- evidence of good and emerging practice through increasing capacity, reducing bureaucracy and joint working.

A5 Reviewing the evidence

Once studies had been scoped, the research team obtained full copies of all sources believed to be the most pertinent to the review. They summarised key findings from the sources deemed to be most appropriate for the review into an agreed template, describing the evidence under relevant thematic headings.

Recently published reports

The Local Government Education and Children's Services Research Programme is carried out by the NFER. The research projects cover topics and perspectives that are of special interest to local authorities. All the reports are published and disseminated by the NFER, with separate executive summaries. The summaries, and more information about this series, are available free of charge at www.nfer.ac.uk/research/local-government-association/

Implementing outcomes based accountability in children's services: an overview of the process and impact

NFER was commissioned to identify the impact of the OBA approach on LA practice in children's services through nine case studies (18 interviews with strategic and operational staff). The main findings are presented in a thematic report with further details as case studies.

www.nfer.ac.uk/publications/OBA02/

Local authority approaches to the school admissions process

This report gathers the views of local authority admissions officers on the strengths and weaknesses of different approaches, as well as the issues and challenges they face in this important area. Key findings show that, in most areas, the process was being implemented with fairness, efficiency and clarity.

www.nfer.ac.uk/publications/LAW01/

Children and young people's views on web 2.0 technologies

This research focused on how web 2.0 technologies allow users to share, collaborate and interact with one another. The project explored the potential of using these tools to collect the views of young people and to involve them in their local community.

www.nfer.ac.uk/publications/LWT01/

For more information, or to buy any of these publications, please contact: The Publications Unit, National Foundation for Educational Research, The Mere, Upton Park, Slough, Berkshire SL1 2DQ, tel: +44 (0)1753 637002, fax: +44 (0)1753 637280, email: book.sales@nfer.ac.uk, web: www.nfer.ac.uk/publications.

LG Group **research report**

Building on the initial scoping study carried out by the NFER for the LG Association early in 2010, this literature review aimed to identify evidence of changes and improvements in child protection practice since the Laming review of March 2009.

The findgings suggest developments across a wide spectrum of practice, specifically in:

- training and professional development
- capacity and recruitment
- improvements in relationships and understanding
- interagency working
- quality assurance and monitoring
- serious case reviews
- referrals and assessments.

It is important reading for those managing, commissioning or carrying out child protection work in local authorities and their partner agencies.

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