INSPECTION OF CHILD PROTECTION SERVICES

Cambridgeshire County Council

November 1998

SOCIAL SERVICES INSPECTORATE

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- to monitor the implementation of Government policy for the personal social services.

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Inspection Summary

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1.1 In April 1997 the Social Services Inspectorate undertook an inspection of the child protection services in Cambridgeshire's Social Services Department. This inspection took place at the request of the Parliamentary Under Secretary in the Department of Health following the non-accidental death of Rikki Neave, a child on Cambridgeshire's child protection register.

1.2 The 1997 inspection identified serious deficiencies in the standard of child protection services in Cambridgeshire. The Department of Health asked the authority to prepare and implement an action plan to address the forty recommendations of the report. A further inspection took place in November 1998 to evaluate the extent to which these recommendations had been fully implemented and whether Cambridgeshire now had an effective child protection service in place. This report covers the findings of the 1998 inspection.

1.3 During the period between the two inspections there were significant changes in the senior management and organisational arrangements in Cambridgeshire. Shortly before the 1997 inspection report was published in November 1997 the previous Director left to take up another post. An Acting Director was appointed until a new Director took up post in February 1998. A new Assistant Director for Children's Services arrived shortly after. On 1 April 1998 the old Cambridgeshire authority was devolved into the new authorities of Cambridgeshire and Peterborough.

1.4 This was the context in which the authority was implementing the action plan following our earlier inspection. Cambridgeshire aimed to complete the process in time for local government reorganisation on 1 April. In practice the timescale slipped significantly. These delays in implementing the action plan made it difficult for inspectors to fully judge its effectiveness on child protection services. However, following initial feedback on our findings the Director has taken forward a further action plan that, when fully implemented, will address the outstanding issues that we have identified.

Summary of the Key Findings

Policy and Procedures

1.5 The SSD and the ACPC had introduced their new child protection and children in need policies and procedures on 5 May. This was later than they had planned. Nevertheless, we considered that the revised policies and procedures were helpful, consistent with current

Government guidance and provided a framework within which staff could deliver coherent assessments and child protection plans. The procedures, based on a system known as Assessment, Planning, Implementation and Review (APIR), had been introduced by the

SSD using a combination of training and consultation with staff at the front line, prior to its final publication. The social work teams were given considerable help in implementing the procedures. However staff told us that implementation had been rushed.

Organisation

1.6 The authority had implemented a new structure for children's services. The final structure addressed the issues of providing efficient management and supervision but there had been significant implementation problems. The SSD's Children and Family Services had undergone a restructuring that was planned under the guidance of the interim Director but implemented during February and March 1998. The restructuring involved caseholding senior practitioners undertaking some of the supervisory responsibilities of team managers to lighten the latter's workloads, and enable them to spend more time on monitoring and quality assurance. However, the new Director identified that the arrangements were not a sufficient solution, and a further restructuring was required. During our time in Cambridge the final touches were being put to the structure, and relevant appointments were being made. The number of teams reduced from 12 to 9, with each having a team manager and one or more dedicated assistant team managers (ATMs) to be responsible for supervision and support of practitioners. The final date for implementation of this new structure was 30 November 1998.

1.7 Councillors were involved in monitoring the implementation of the action plan and took their responsibilities very seriously. They had received full information on progress from officers and were aware of the problems with child protection conference timescales, recruitment and the structure of the teams. However, we considered that councillors needed continuing assistance to understand fully the complexity of the issues faced by the service.

1.8 The new Director advised the Chief Executive in April that the implementation of the action plan was well behind schedule, that some of the problems were very deep seated and that this would affect the speed of service improvements.

Interagency Arrangements

1.9 The reconstituted Area Child Protection Committee (ACPC) had established a solid basis for interagency arrangements and the Chair was giving a positive lead to its work. Some agencies were still concerned about the continuing over-representation by the SSD at too senior a level, and this was being reconsidered. Since the inspection the SSD representation had reduced to 2 officers, the Director and Assistant Director (Children). However, the SSD was no longer over-dominant and agency representatives spoke very positively about how well they worked together within the ACPC and its sub-committee structure, in beginning to deliver change. The ACPC's work programme was comprehensive and appropriate although some important items on it did not have timescales, and there was evidence that a significant number of key issues had yet to be addressed or finalised.

Management

1.10 Since the 1997 inspection the Senior Management Team had been almost entirely reconstituted, with only one of its original members remaining. The new Director and Assistant Director of Children and Families had been in post since February and May 1998 respectively. At third tier there were two operations managers, who had previously held more senior posts in the former structure, who were responsible for the delivery of child care services in the north and the south of the county respectively.

1.11 The new Director and Assistant Director had instituted a deliberate policy of engaging with practitioners and team managers directly, and having some direct involvement in particularly problematical cases. This strategy was designed to win the confidence of staff, as well as to model good management for other managers whose management practice was still not as facilitative or incisive as it might have been.

1.12 Team managers and operations managers did not have a culture of actively managing the service by identifying potential areas of difficulty or increased pressures on staff, and developing strategies to respond to them. There was still a practice of reacting to problems as they occurred by referring them up the line and expecting the Directorate to provide ready solutions.

Social Work Teams

1.13 Action had been taken by senior managers to try and address issues of morale and serious difficulties in teams but there were continuing problems that required active management. We found that staff morale continued to be low. We identified a degree of cynicism borne out of the rapid and late implementation of the new child protection procedures, the implementation of the Looking After Children (LAC) procedures on 5 November 1998, and the two restructurings. Although staff appreciated the interest which their new senior management were taking in their work, and the way they were sharing decision making about risk, some were cynical about its continuing in the longer term. They recognised that the Director and Assistant Director were actively sensitive to their problems, but realised that this could only be a short term strategy, and considered that some of the residual managers from previous regimes still retained the old approach.

1.14 One of our key recommendations in the previous inspection was that the SSD needed to have a strategy in place in order to support teams which were seen to be failing. This had not been achieved satisfactorily. In March 1998 it emerged that a situation had developed in two teams where they were not allocating referrals, failing to take action on child protection concerns and concealing these problems. This was the result of poor first line management and a lack of monitoring at a more senior level. Newly appointed first line managers brought this to the attention of the new Director who addressed the issue. Senior managers accepted that they still did not have appropriate systems to prevent this happening in future. One of the teams we visited was on the verge of collapse due to pressures of work, caused by a sudden spate of staff absences due to sickness. Since the inspection the Director has produced an action plan which when implemented should address the problem.

Allocation of Work

1.15 Although action had been taken to improve the monitoring of workloads and pressure points, there were increasing workload pressures. In a significant number of teams cases were unallocated, de-allocated or held on duty. The situation was clearly proving very difficult to control and was a cause for concern. A system had been set up for team managers to report unallocated cases and staff vacancies on a monthly basis. Senior managers hoped that the new structure would allow closer monitoring by team managers but there were no systems to ensure this. We were concerned that some of the teams were not strong enough to cope with the increasing workload pressure and not confident that there was enough capacity to re-allocate the work of senior practitioners to achieve the new structure. There was no slack in the system which could allow resources to be deployed to assist teams when their pressures became unmanageable. This was despite the fact that the Council had granted

the SSD £1m to be used over a two year period to develop family support services and better preventative practice. The Council had substantially protected children's services from the impact of service reductions. Savings of nearly £2.5m had been made during 1998/99 in the rest of the SSD. During this time all vacant posts in the children's field care teams had been subject to active recruitment but vacancies had been hard to fill. This had severely affected service delivery.

1.16 During 1998 there had been considerable movements of resources from the south to the north of the county. The Director informed us that this had to be carefully managed so that pressure on teams which lost resources could be avoided. However, more movement of resources was still needed. Since the inspection the Director has produced an action plan which when fully implemented should address the problem.

Social Work Practice

1.17 The new APIR procedures provided a better procedural framework for social workers to follow. In the work that had been done since their implementation there was evidence that a clearer style of assessment and evaluation was beginning to emerge. However, staff complained that they were somewhat overwhelmed by the new procedures, and did not clearly understand how they could be used in the most efficient way. This was compounded by the implementation of the LAC materials, and the fact that other procedures had not been revised to accommodate the introduction of these new ones.

1.18 There had been some improvement in working with violent and resistant families. However, we did not think that sufficient steps had been taken to manage the response to all these families. We saw some cases where the SSD was being denied access to children by families, in some instances because the families had been advised to do so by their own lawyers. In response to this the SSD were relying on monitoring arrangements, for instance by asking other professionals such as schools or health staff to keep an eye on things and alert the SSD if there were problems. We were told of situations where staff had been confronted with violence and had not felt very well supported by more senior managers. Since the inspection the Director has introduced an action plan, which when fully implemented should address this problem.

Interagency Working

1.19 In spite of the positive developments in the ACPC some practices between social services health, education and police at operational level were worrying. Initial and review child protection conferences and core groups had frequently been postponed because they were inquorate. We were not satisfied that there was sufficient understanding of the

importance of child protection issues amongst all relevant agencies at operational level including some staff in paediatric and psychiatric services for both children and adults. It was reported to us that in some parts of the county some agencies were reluctant to become involved in child protection work for fear of being involved in areas of difficulty and possible public concern.

1.20 Working relationships had improved considerably between the SSD and its legal advisers, and with the police, and the quality of co-operation between these agencies had been helpfully underpinned by the implementation of new protocols.

Public Perception

1.21 The public were still mistrustful of the SSD. Staff felt that lack of trust impacted on their ability to engage effectively with families. Although senior managers were pursuing a policy of being as open as possible with the media and the public about the work of the service the public information strategy in relation to child protection was still poorly developed. There were plans in place to address these issues.

Reviews of Cases under Part 8 of Working Together

1.22 In 1998 four cases had required review by the ACPC as required by Part 8 of the Department of Health guidance on Working Together. In three of the cases a child had died, and in one a child had suffered serious injury. In two of the cases the reviews were carried out jointly with Peterborough ACPC. These cases occurred early in 1998 before Peterborough became a unitary authority and before the new child protection procedures had been implemented. The Part 8 reviews on these cases highlighted serious concerns about interagency work, sharing of information, recognition of types of abuse, and accurate recording.

Conclusion

1.23 The senior management team were aware that they had not achieved as much progress as they would have wished in implementing the action plan. The new procedures provided the basis for a sound child protection system, but at the time of the inspection had not had sufficient impact on the practice and culture of the department to achieve a consistently satisfactory standard throughout the county. There was a clear improvement in the work on newly referred cases in most parts of the county but the new procedures had not had the same impact on established cases. This was particularly true of work with families with

hostile and resistant parents.

1.24 We had reservations about how long it would take to achieve a fully effective service and were concerned that there were still some major obstacles to overcome. We considered that the current service structure was fragile and that because there was no slack in the system, resources could not easily be deployed to respond to crises. We understood from senior managers that they were hopeful that the new structure would provide a more efficient intake and assessment service in the county, and that the resources reallocated to the north would go some way to equalising the ability of teams to respond effectively. However, we thought that more needed to be done in order to enable practitioners and managers to recognise and respond to issues when they occur.

1.25 Through the leadership of the new Chair of the ACPC members were working well together, and a comprehensive work programme had been introduced, although it had yet to be completely programmed. However we had concerns about the effectiveness of some of the joint practice between agency staff. More commitment was required to involvement in the work, including attendance at child protection conferences and interagency core groups.

1.26 While in general we continue to believe that full implementation of the action plan will lead to an effective service, we are concerned that there were three serious issues which could prevent this. These were:

- the extent to which services were over-stretched with no room for contingencies;
- the lack of strategies for identifying and dealing with failing teams; and
- the lack of consistent support to staff in dealing with hostile and resistant families.

1.27 Since the inspection, and following early feedback to senior SSD managers and the Chief Executive of the authority, urgent action has been taken by the Director of Social Services to address these concerns. Detailed action plans have been prepared with timescales for implementation. We are satisfied that the new senior management team are determined to achieve an effective child protection service and, if fully implemented, their management action plans will meet these concerns.

Reading the Remainder of this report

1.28 This report is set out in a way to enable the reader to have an understanding about every aspect of the inspection. Chapter 1 is a

summary of the key themes which have emerged from the inspection. Chapter 2 summarises the issues on which the SSD needs to take further action. Chapter 3 gives a brief description of the aims and methods of the inspection. Chapter 4 sets out the context in which social services is operating. Chapter 5 and each subsequent chapter detail the evidence which led us to our conclusions. In each of these chapters the findings relate to the implementation of the recommendations arising from the previous child protection inspection and the extent to which it has been effectively carried out.

1.29 In addition, the appendices give fuller information about:

- the standards and criteria against which our judgements have been made (Appendix A);
- the method used in the inspection (Appendix B);

- who we interviewed as part of this inspection (Appendix C);
- details of the training and experience of first line managers and operational staff in the SSD (Appendix D);
- management structure chart (Appendix E).

1.30 Inspectors would like to extend their thanks to those who contributed to the inspection and particularly to those responsible for the complex task of organising it.

Recommendations

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2.1 The inspection identified a number of areas in which there is significant further work required to achieve the full implementation of the recommendations of the last inspection. We also found some new issues that need urgent attention. These recommendations are addressed to the social services department, other parts of the local authority and the Area Child Protection Committee (ACPC).

Recognition and Referral

2.2 The ACPC agencies need to ensure that all relevant staff are clear about the kinds of information that they should be providing to social services when making a child protection referral, and the responses they might expect from the SSD. (para. 5.3)

2.3 The SSD and the ACPC need to progress their strategies on Public Information to ensure that the public are properly informed about child protection. (para. 5.5)

2.4 The SSD needs to further develop in all teams its monitoring systems to ensure consistent responses to child protection referrals. (para. 5.10)

Immediate Protection and Identifying the Nature of Concern

2.5 The SSD and the ACPC should provide relevant members of operational staff with guidance in an easily accessible format in addition to the more comprehensive set of Policies and Procedures already provided. (para. 6.5)

2.6 The SSD and the Police, and if appropriate, other agencies, should conduct an early review of their joint operational protocols to ensure that where the circumstances warrant them, joint enquiries do take place. (para. 6.7)

2.7 The SSD, their legal advisers, the police and other relevant agencies should undertake an evaluation of cases of children who have been subject to Police Protection. (para. 6.8)

Investigation and Initial Assessment

2.8 As a matter of urgency the SSD should implement its proposals to identify and respond to the needs of failing teams. (para. 7.3)

2.9 The SSD should continue to review its training strategy to ensure that staff have the necessary skills to communicate effectively with children. (para. 7.9)

Decision Making about Registration at Child Protection Conferences

2.10 The SSD and the ACPC must urgently ensure that staff in each member agency are fully aware of the importance of their participation in Child Protection Conferences. (para. 8.6)

2.11 The SSD and the ACPC, through training and line management, should reinforce to staff the purpose of Initial Child Protection Conferences (ICPCs) as defined in "Working Together". (para. 8.7)

2.12 The SSD and the ACPC should develop the role of Child Protection Co-ordinators in quality assurance. (para. 8.16)

2.13 The SSD must increase their efforts to ensure that the complaints and representations procedure is effective, and that there are separate ACPC procedures for making representations about the interagency child protection process. (para. 8.18)

Comprehensive Assessment

2.14 The SSD should develop agreements with other agencies including those represented on the ACPC about commissioning and contributing to comprehensive assessments. (para. 9.4)

2.15 The SSD should continue to provide support to staff in developing their skills in assessment. (para. 9.6)

2.16 The SSD should continue to develop a range of monitoring and audit systems for comprehensive assessments. (para. 9.8)

Planning

2.17 The ACPC and the SSD must ensure that review child protection conferences are quorate and attended by the agencies who were present

at the ICPC. (para. 10.5)

2.18 Social Services Committee (SSC) members should monitor the effectiveness of staff deployment in the Children's Service. (para. 10.11)

2.19 As a matter of urgency the SSD must ensure that it supports staff dealing with hostile and unco-operative families. (para. 10.14)

2.20 The SSD must ensure that as a matter of routine, managers monitor case records. (para. 10.16)

Management

2.21 The SSD should review the way administrative support is provided to teams. (para. 11.24)

Record Keeping

2.22 The SSD should provide training for staff on methods of case recording. (para. 12.8)

Policy

2.23 The SSD should ensure that staff not only comply with procedures but fully understand what the procedures are intended to achieve. (para. 13.6)

2.24 The SSD should ensure that the Child Protection and Review Co-ordinator plays an active role in quality monitoring and assurance. (para. 13.9)

Staff Competence and Deployment

2.25 The SSD should consider introducing a requirement for post qualification accreditation before staff undertake Section 47 enquiries. (para. 15.4)

Introduction

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3.1 This inspection of child protection services in Cambridgeshire took place between 3-13 November 1998. The inspection was carried out by five Inspectors and a Lay Assessor. It took place at the request of Ministers following a previous inspection of child protection services in Cambridgeshire in 1997 following concerns raised by the death and neglect of Rikki Neave. The inspection in 1997 concluded that there were serious concerns about the quality of child protection services being delivered by Cambridgeshire SSD and that extensive action was needed by them to put matters right. The SSD devised an action plan which was monitored by SSI. The 1998 inspection evaluated its implementation one year after the publication of the earlier report.

3.2 The inspection used standards and criteria drawn from legislation, guidance, research and understandings of good practice. The inspection was conducted on the basis of an evaluation of the extent to which each of the 40 recommendations made in the 1997 report had been successfully implemented. During the course of this inspection, 72 interviews were conducted involving 84 staff and service users, 36 case files and 2 completed reports of Part 8 reviews were examined.

3.3 Further details of the methodology used in the inspection can be found at Appendix B.

Local Authority Profile

4

4.1 In April 1998 Local Government Reform (LGR), saw the separation of the City of Peterborough from the former county of Cambridgeshire. This reorganisation resulted in all the services provided by the former Cambridgeshire Social Services Department being disaggregated and assigned into the two new authorities.

4.2 The new Cambridgeshire's principal area of population is the City of Cambridge, the remainder of the county being predominantly rural, although Huntingdon, March, Wisbech, St Ives, St Neots and Ely are also significant areas of population. The new county is typified by relative affluence in the south and features of rural deprivation in the north of the county. In particular the Fenland area scores highly on a number of demographic indicators of deprivation including unemployment and poor educational attainment.

4.3 The population of new Cambridgeshire is 544,600.

4.4 The SSD budget was set at approximately 70% above standard spending assessment (SSA). Children and families services accounted for 33% of the SSD budget overall; the average figure for comparable authorities being 23%. The budget for children and family services for the current year was £20.4 million; this was 45% above SSA. The SSD had a disproportionately high expenditure on agency placements (£2.3 million) and on legal fees (nearly £1 million).

4.5 The overall SSD budget for 1998/99 was required to make up a £1.5 million overspend from the previous financial year. Expenditure on children and family services had been protected and had included an injection of £0.5m for two years. This had resulted in much lower than average spending on adult services, particularly for older people. This had caused considerable pressure on adult services.

4.6 The number of children looked after per 10,000 population was 4, compared with the national average of 4.7 and with neighbouring authorities which averaged 3.45 at March 1998.

Child Protection

4.7 The numbers of children on the Child Protection Register (CPR) had risen from 262 in April 1998 to 321 by the end of September. The greatest rate of increase was in the north of the county, although there were increases in registrations in the majority of the teams over this period. The greatest increase had been under the category of neglect, and this had been a consequence, in senior managers' views, of a greater ability of staff in some parts of the county to identify risk. Senior managers judged that the increase in children looked after was due to defensive practice on the part of practitioners and first line managers in the wake of the criticisms arising out of the Rikki Neave case and the last child protection inspection. This defensiveness may also have accounted for the apparent high rate of applications for care proceedings.

4.8 Because this inspection was looking at the work in a newly reconstituted local authority it was not possible to draw comparable data against the national datasets of other SSDs. The SSD had produced comparative data with neighbouring SSDs which indicated that the rate of registration per 10,000 under 18 years was 2.3 against the national average of 2.8 and a local average of 2.12.

4.9 The tables below indicate the attendance of agencies at child protection conferences. Attendance by agencies in different parts of the county tended to vary, with the best performance being in the Huntingdon area, although the level of attendance overall was unsatisfactory.

Attendance by Agency/Professional at all Child Protection Conferences

Attendances	Total of relevant conferences (both Initial and Review)			Percent attendances at relevant conferences
N=196 Conferences				
Police	101	of	182	55
Education	94	of	130	72
G.P.	15	of	171	9
Community Paed.	46	of	143	32
CP Nurse Advisor	38	of	141	27
Paed. Hosp.	7	of	43	16
Health Visitor	116	of	148	78

Attendance by Agency/Professional at Initial Child Protection Conferences

Attendances	Total of relevant conferences (Initial Only)			Percent attendances at relevant conferences
N=78 Conferences				
Police	57	of	73	78
Education	39	of	54	72
G.P.	10	of	67	15
Community Paed.	23	of	53	43
CP Nurse Advisor	21	of	59	36
Paed. Hosp.	5	of	20	25
Health Visitor	45	of	58	78

Attendance by Agency/Professional at Review Child Protection Conferences

Attendances	Total of relevant conferences (Review Only)			Percent attendances at relevant conferences
N=118 Conferences				
Police	44	of	109	40
Education	55	of	76	72
G.P.	5	of	104	5
Community Paed.	23	of	90	26
CP Nurse Advisor	17	of	82	21
Paed. Hosp.	2	of	23	9

Recognition and Referral

5

STRENGTHS	AREAS FOR DEVELOPMENT
• The APIR system had begun to clarify the criteria for distinguishing between child protection and children in need referrals. • Practice was good in keeping referrers informed of progress and feeding back to them.	•Information for the public and for service users was poorly developed. •Cases awaiting assessments were being held for longer than was advisable in some teams. •Checks with the child protection register were being made inconsistently.

Public Information about Child Protection Concerns

5.4 ***The Director of Social Services and senior managers must ensure that the SSD reviews its information for the public about making a child protection referral.***

5.5 The SSD had produced a helpful leaflet for the public on reporting child protection concerns. We considered it to be a clear explanation of what should be done if members of the public had worries about particular children. Unfortunately, the social workers were generally not aware of it, and it had not been well distributed to team offices. Senior managers had continuously pursued a policy of being as open as possible with the media and the public about the complex work of the service. However, they accepted that there was no interagency information available and there was a lack of progress on significant aspects of the social services "Positive Communications Strategy". **We were concerned that relatively little progress had been made in respect of this recommendation.**

Consistency of Responses to Referrals

5.6 ***The Director of Social Services and senior managers must ensure that systems are in place to monitor actively performance and consistency between teams.***

Initial Assessment

5.7 From our reading of the case file sample our assessment was that 25% of the initial assessments had weaknesses. On interview, a more reassuring picture of the quality of these initial assessments emerged. The APIR procedures expect that team managers will follow a common procedure when making decisions on the basis of these assessments. However, we found that there were inconsistencies between teams at this stage of the work. We judged that team managers did not ensure that their decisions were entered on to case records. We also saw evidence that the way decisions were taken, and their quality, was a result of local practices and pressures, rather than of following SSD procedures. We saw one case where repeated injuries to a child on the child protection register were not followed up once it was established that they had not been caused by the person who had been responsible for the injury which had led to the registration in the first instance. Until recently, in two teams there had been some very serious deficiencies in the way that referrals had been handled, and the consequent problems that had emerged were only corrected following a restructuring which had occurred in April 1998. It was likely, in our view, that the new ATM posts in the structure, which was currently being implemented, would bring more rigour and consistency to initial decisions.

Allocation and Assessment

5.8 We were concerned that in three teams cases were being held without being fully assessed, for longer than we considered to be advisable. In some instances, there were probable child protection concerns which were continuing to be handled on duty. This led to inconsistency in the way they were dealt with and delays in reaching a conclusion on what should be the next stage of the work. Although commendably senior managers had introduced a monthly system of "health checks" for teams, in which team managers completed a proforma detailing non-allocation of work and absence of staff, the checks only provided a snapshot of the state of the teams, and did not form the basis of more helpful strategic intervention when there were signs of backlogs developing.

Interagency Checks

5.9 It was not clear that a full record of checks had been made of the Child Protection Register (CPR). There were different understandings of the way in which register checks could be made by staff other than child protection co-ordinators. There was a lack of routine checks being done when child protection concerns were reported about children who were already being worked with by the SSD. We were also concerned that where there were repeated child protection concerns about children who were known to the SSD staff tended not to question previous assumptions which they had made about the case. Some staff claimed that they could find out if a child was on the CPR by checking the SSD's client index system. Senior managers claimed that they could not, and we were not able to establish which version was the correct one. We were very concerned that recent Part 8 reviews undertaken by the ACPC indicated that staff in hospital A&E departments were not checking the CPR when children were presented with injuries. In at least one case this failure had resulted in serious delays in providing proper protection to the child which had had considerable consequences for her wellbeing.

Recording Child Protection Referrals

5.10 There was no requirement to raise a new referral when a child protection enquiry was made on a case which was already being worked with. Similarly, there was no requirement on staff to carry out interagency checks, when a child was born where a decision had been made some months prior to the birth to place the name on the CPR. The procedures should be amended to include these requirements, in order that the most up-to-date picture of the family's circumstances is obtained prior to taking further action.

5.11 **It was noteworthy that the response to referrals since the introduction of APIR had improved and become more consistent. However, more work was needed to ensure consistency throughout the SSD and particularly when other agencies were involved.**

Feedback to Referrers

5.12 ***The Director of Social Services and senior managers must ensure that operational instructions include the requirement to feed back to referrers.***

5.13 The procedures required that staff should routinely feed back information to referrers about the outcome of initial enquiries, and what further steps were being taken in respect of individual cases. A standard letter had been introduced as part of the new procedures and it was notable this was used on a regular basis. The staffs' compliance with this procedure was evident both from case records and from interviews with staff and managers. **This was a satisfactory response to the recommendation.**

Immediate Protection and Identifying the Nature of the Concern
6

STRENGTHS	AREAS FOR DEVELOPMENT
• The new procedures contained clear timescales for response to allegations of abuse. • Helpful operational guidelines had been produced in the form of a laminated flow chart.	•A portable handbook summarising the procedures would be helpful for staff. •More work was needed to ensure that the protocol between the SSD and the police concerning joint enquiries was operating effectively. •There was an over-readiness to resort to police protection.

6.1 In the report of the previous inspection SSI made recommendations on the basis of our findings under these standards. The agencies' responses to the recommendations are set out below.

Responses to Allegations of Abuse

6.2 ***The ACPC should review and update its procedures, and include precise timescales for response to allegations of abuse.***

6.3 The ACPC procedures were now satisfactory. The APIR framework was useful and provided a helpful structure for SSD staff undertaking early and ongoing work in both child protection and family support. The ACPC procedures were underpinned by timescales for completion of the various parts of the process which we considered to be appropriate. It was clear from the records of work undertaken since the procedures were introduced that staff were trying to comply with them. There was a clarity in case file recording since the implementation of APIR which had not previously existed. **This was a satisfactory response to the recommendation**.

Operational Guidance

6.4 ***The Director of Social Services and senior managers must produce operational instructions in an easy to use format based on the ACPC requirements, and ensure that they are available to all staff undertaking investigations.***

6.5 The procedures were a comprehensive and helpful combination of policy, process and operational guidance but this mixture resulted in a bulky manual which staff found daunting to use and also difficult for them to have by them at all times. A helpful laminated card had been produced, providing a simple guide to the process of assessment in the form of a flow chart. Many staff expressed the view that it would be helpful for them to have a smaller handbook which detailed the key steps they needed to take when conducting Section 47 enquiries. This would be something that could be easily carried personally, and could be consulted as the need arose. As it stood staff were getting into the habit of photocopying particular sections which they considered relevant but which may not always be the ones they would require. This practice could in time result in these copies becoming outdated and staff following incorrect procedures. **We considered that the response to the recommendation was satisfactory but that in addition the staff would benefit from a small handbook detailing key practice guidance.**

Joint Protocols Between the Police and Social Services

6.6 ***The Director of Social Services and senior managers must draw up a protocol with the police covering the circumstances in which single as well as joint agency investigations should take place.***

6.7 A joint protocol had been drawn up between the police and social services about the conduct of Section 47 enquiries. It allowed discretion about whether a single agency, or joint, enquiry was indicated, and in general this discretion was exercised appropriately in practice. Social services staff identified some problems in communication with the police Family Protection Unit (FPU). They said they sometimes had to leave messages with the police on an answerphone, and there was a perception on the part of social services that FPU officers were not always available to undertake joint enquiries. There was one case in the sample where, although an agreement had been made to conduct a joint enquiry, in the event a police officer was not available. Thus the SSD undertook the enquiry as a single agency, and the alleged perpetrator of the assault on the child was not interviewed for almost a month after the initial referral. **It was commendable that a joint protocol had been agreed but an early review of the operation of the joint protocol would be helpful to avoid such problems in the future.**

Police Protection

6.8 There was an over-readiness on the part of the SSD to resort to police protection, rather than Emergency Protection Orders (EPOs), because of administrative and operational convenience. We were told that without notice it was often difficult to apply for an ex-parte application for an EPO to be made and that the courts were hard pressed to make time for such contingencies. In the year up to the 31 October 1998, 58 cases had resulted in police protection in the county of Cambridgeshire. Twenty two of these were taken out within the area of the new Cambridgeshire social services, the remainder being taken in Peterborough. **We would suggest that the SSD, the police and the SSD's legal advisers undertake an evaluation of these cases to identify:-**

- **whether police protection was the most appropriate course of action;**

- **how many of them were carried out by agreement between case holding teams and the police;**
- **how many resulted in an EPO or child assessment order; or**
- **how many ultimately resulted in the making of care orders or supervision orders.**

Investigation and Initial Assessment

7

STRENGTHS	AREAS FOR DEVELOPMENT
• The joint training on investigations between the police and the SSD was of good quality.	•There was no management strategy to support struggling teams. •Recording of social workers' contacts with children was poor. •The wishes and feelings of the children was not always a central focus of child protection enquiries.

6.9 In the report of the previous inspection SSI made recommendations on the basis of our findings under these standards. The agencies' responses to the recommendations are set out below.

The Effective Operation of Social Work Teams

6.10 ***The Director of Social Services and senior managers must ensure that decisive action is taken at an early stage if a team is operating ineffectively.***

6.11 The SSD had no clear management strategy for dealing with struggling teams. In recent times three teams had been failing to perform to a satisfactory standard. Two of them had failed seriously and were in the process of recovery and one was, in our judgement, currently in danger of collapse. Previously senior management had relied on failing teams being brought to their attention because they had no other means of ensuring that they would be identified. Monthly "health checks" had been introduced whereby teams reported on their performance but these were not an effective answer because they only gave indications of work not done, and not an analysis of potentially more chronic problems in the teams. Some part solutions had been attempted by management, such as farming work out between teams, temporarily transferring staff, and securing agency staff. We report on this matter further in Chapter 13. **At the time of the inspection there was no effective strategy in place to respond to the needs of failing teams although subsequently senior managers have developed proposals which if fully implemented were likely to provide an adequate response in these circumstances.**

Video Recording Interviews with Children

6.12 ***The Director of Social Services and senior managers must review the practice of video recording interviews with children to ensure it follows the Memorandum of Good Practice and is in the child's best interest.***

6.13 The SSD and the police had revised their procedures on the conduct of video taped interviews with children as part of the enquiries process. Commendably these procedures were supported by good quality, extensive training for both social workers and police officers, and had resulted in a better understanding of respective roles and functions. However, we were still concerned that police officers tended, for the most part, to lead interviews with social workers in support. Although nationally there is a tendency for police officers to lead these interviews, this is not supported by guidance, and in many authorities, it is done interchangeably between police officers and social workers on the needs and circumstances of the case. The very good training in Cambridgeshire allows for it to be provided by staff in the SSD, and it should be regarded as wasteful of that training that social services staff are trained in these skills but then mainly do not use them. The introduction of the "pre-substantive" interview, to establish the justification for a further video taped interview, had helped to reduce the previous over-reliance on this procedure. We were satisfied that children were no longer being subjected to video taped interviews unnecessarily.

Decisions Not to Take Cases to Conference

6.14 ***The Director of Social Services and senior managers must agree a timescale for practice managers to pass cases which are investigated but not conferenced to field care managers.***

6.15 Decisions not to proceed to an Initial Child Protection Conference (ICPC) were taken by child protection co-ordinators following consultation with the team manager and the social worker responsible for the case. On the evidence of the case sample these decisions were being taken correctly. They were made on the basis of consultation with other agencies and were notified to the Operations Manager as a matter of routine. This replaced and overcame the deficiencies in the previous procedure about which we had been concerned. **We considered that this recommendation had been fully implemented.**

Staff Skills in Communicating with Children

6.16 ***The Director of Social Services and senior managers must ensure that all child protection workers are trained in communicating with children.***

6.17 Eighteen of the children in our case sample were not of an age to interview but commendably all of them were seen by social workers during the Section 47 enquiry. However, social workers did not always make it clear in the case record that the child had been seen. In the other 18 cases, 16 of the children were interviewed and of those, 5 were interviewed on their own. Staff gave us different views of their ability to communicate effectively with children. Although training had been provided during the last year on this issue, some social workers felt that it had not extended their skills. A significant number of other social workers did benefit from this training, and still others had gained further benefits through the video interviewing training. However, despite this good performance in seeing and interviewing children we were concerned to conclude from reading case files and interviewing staff that the wishes and feelings of children were not always taken account of in subsequent decisions. The welfare of the child was not always the key focus

of the work. On balance social workers were over concerned with the preoccupations of the parents, and lost sight of their first responsibility to the welfare of the child. In one case a decision had been made to remove a child's name from the CPR once the alleged perpetrator had left the family home, without any discussion with the child who was socially isolated, and who remained with a hostile and unco-operative mother.

6.18 If the SSD is to fully comply with this recommendation it is important that the SSD and the ACPC continue to review their training strategy to ensure that staff have the competencies to communicate appropriately with children.

Decision Making About Registration at Child Protection Conferences

8

STRENGTHS	AREAS FOR DEVELOPMENT
• Initial child protection conferences were chaired by skilled child protection co-ordinators. • Core groups were appointed in every case where the need for an interagency child protection plan was identified.	•The timescales for convening ICPCs were not being met. •Lack of attendance at ICPCs by key agencies was a serious concern. •Greater clarity was needed for staff of all agencies about the purpose of an ICPC. •The unavailability of skilled minute takers at ICPCs had caused difficulties in the production of adequate records of the meetings. •Staff failed to provide information to service users about the complaints and representations procedure.

8.1 In the report of the previous inspection SSI made recommendations on the basis of our findings under these standards. The agencies' responses to the recommendations are set out below.

Timescales for Holding Child Protection Conferences

8.2 ***The ACPC should ensure that ICPCs are held within 8 working days from the date of referral, and that this requirement is stated in the child protection procedures.***

8.3 The new procedure followed government guidance and required that ICPCs should be held within 8 working days from the date of the referral or 15 days at the latest. Twenty six of the cases in the sample were conferenced. Only one case in the sample met that requirement and a further four were held within 15 working days. The SSD continued to monitor the timescales for ICPCs and this data indicated that by July still only 47% of the conferences were being held within 15 days. By the end of September it had improved to

58%. Senior managers acknowledged that this was still not an acceptable performance, but it represented a clear trend of improvement from the 25% which had been identified a month previously.

8.4 The reasons given for the failure to hold conferences in line with current guidance was that it was often difficult for other agencies to attend at short notice. Inspectors also question whether the new ACPC procedures have been effectively implemented by other agencies. In a number of cases a date had been set for an initial conference within 8 days or within 15 days, but then a significant number of them were subsequently postponed because they were inquorate. Some conferences were proceeding without key people being in attendance. This picture was confirmed in interviews with staff who stated that deferment of conferences for this reason was a regular problem.

8.5 The explanation from the relevant ACPC agencies for this situation was as follows:-

- **Education**: the expectations on schools were far greater than they perceived they could meet, due to the cost of providing supply teachers to cover attendance, and the newly introduced requirement for staff to attend core groups, as well as conferences. The LEA representative on the ACPC stated that although schools budget allocations had been top sliced to try to accommodate attendance at conferences, the money was not sufficient.

- **Police**: non-attendance was explained by a lack of available officers to attend at short notice, and in a small number of incidents an unwillingness to share information in the conference setting for fear of prejudicing or contaminating evidence in criminal proceedings.

- **Health Visitors**: Cambridge Health Authority had recommissioned its health visiting service which had resulted in a reduction of posts in the Huntingdon area and a reduction and a redesignation of the remaining health visitors and school nurses as community nurses in Cambridge. This was said to have meant that the numbers of available staff to attend conferences, as well as undertaking other duties, was significantly reduced.

See tables relevant to the above in Chapter 4.

8.6 **We considered that the relatively poor attendance at child protection conferences reflected an insufficient appreciation on the part of some members of staff of ACPC agencies of the importance of child protection. It was in danger of reducing the importance of child protection conferences in protecting children. It should be regarded as an urgent matter for the SSD and the ACPC to correct.**

The Purpose of ICPCs

8.7 There was some confusion on the part of social services and other agency staff about the purpose of ICPCs. Some thought it was necessary to provide substantial evaluated information prior to the conference which would then in effect undertake a comprehensive assessment of the child and family's needs. It was seen as being the role and responsibility of the social worker leading the enquiries to produce the assessments, and it was exceptional for other agencies to provide written reports for conferences, separate from information that had been given to the social worker verbally during the enquiries. **The SSD and the ACPC need to reinforce to staff that the purpose of the ICPC is to**

gather the already available information from all agencies, to evaluate whether there is a need for a child protection plan. The purpose of the fuller assessment is to inform the child protection plan once the need for it has been established.

Child Protection Co-ordinators

8.8 ***Members should ensure that there are sufficient child protection co-ordinators to chair conferences.***

8.9 Since 1 October 1998 there had been 3.5 Whole Time Equivalent (WTE) child protection co-ordinator posts which were fully staffed at the time of the inspection. Each co-ordinator took responsibility for a particular area of the county. They were regarded as highly skilled in chairing the meetings, in handling difficult situations, and in putting parents and children at their ease. Service users, in their questionnaires and in interview, spoke highly of the way they had been treated in child protection conferences, saying they had been treated with respect and courtesy and had been kept informed by the Chair as to what was going on. **We considered that this was a satisfactory response to the recommendation.**

8.10 The venues for child protection conferences were not always as helpful or welcoming as they might have been. There may be benefit in the SSD considering whether it should enhance the facilities in which child protection conferences take place, to ensure that they are comfortable and welcoming. Simple courtesies such as the provision of a cup of tea or coffee, and a comfortable waiting area could be provided to give testimony to the spirit of partnership and respect which staff said underpinned their work.

Minutes of Child Protection Conferences

8.11 ***The Director of Social Services and senior managers must ensure that minutes for all child protection conferences are produced within a reasonable timescale, to enable a child protection plan to be developed, and provide the evidence on which decisions were based.***

8.12 The major problem with conferences in the time just prior to the inspection was the lack of skilled minute takers to take a note of the meeting and to produce an accurate record. We saw a considerable number of cases where only the decisions and recommendations had been recorded and shared with families and other agencies. These omissions were serious in our judgement, and caused problems for legal advisers and families in taking cases forward subsequently. By the time of the inspection a full complement of minute takers were in place. However, we were concerned to learn that in order to cover these vacancies in the time running up to the inspection, staff from commercial agencies had been used who neither had the experience or understanding of child protection issues to cope with the conference process, as well as to identify key issues from the discussions. After the inspection the SSD and ACPC had reviewed its practice in this respect and ensured that adequate resources were to be always available to support the conference process, if necessary by having staff in reserve who were trained minute takers. **We were satisfied with this response.**

The Appointment of Core Groups

8.13 ***The Director of Social Services and senior managers must ensure that the ICPC appoints a core group of professionals to work with the family, and to devise a child protection plan based on the recommendations of the conference.***

8.14 An interagency core group was appointed in every case where a child's name was placed on the CPR. Core groups varied considerably in their effectiveness and some worked very well. Variation seemed dependent on the commitment of social workers and team managers to the core group process, and also the commitment of other agency staff to attending and playing their part. In a significant number of cases the core groups did not meet regularly because representatives of other agencies did not turn up. In some instances, interagency members did not appear to understand the role and the function of the core group, or the part they had to play in child protection. Core groups were chaired by the team manager or a senior practitioner and the minutes were usually taken by the case holding social worker. In some teams efforts had been made to encourage other members of the group to take the note but this had not been successful. **The recommendation had been partly implemented by ensuring that core groups were always appointed at ICPCs. However agencies needed to make greater efforts to ensure that the groups were effective by staff attending meetings and actively playing their part in the work.**

The Role of the Child Protection Co-ordinator in Monitoring Quality and Providing Advice

8.15 ***The Director of Social Services and senior managers must ensure that the role of child protection co-ordinators is more clearly defined, and strengthened to include their involvement in quality control and advice giving.***

8.16 The child protection procedures required child protection co-ordinators to be formally consulted in the process and, as we have noted, it was their decision whether to hold a child protection conference or not. The SSD intended that the child protection co-ordinators should have a role in auditing the quality of work in social work teams but this was at a very early stage of being implemented. Current evaluation of practice was based on conference attendance, the availability of reports and the adherence to timescales. Beyond this, although child protection co-ordinators met regularly with team managers and operations managers there was no framework for the audit of quality in reports and practice. **Although this recommendation had been responded to we considered that the role of child protection co-ordinators in assuring quality should be further developed.**

Providing Parents with Information about the Complaints and Representations Procedure

8.17 ***The Director of Social Services and senior managers must ensure that all parents are given information about the County Council's complaints and representations procedure.***

8.18 Procedures required staff to provide information to service users about the Complaints and Representations Procedure at the outset of the child protection enquiry. In practice this rarely happened. In one case a service user informed us that on three occasions she had requested information about how to complain, one of those being in writing. Despite her efforts information had not been forthcoming. Staff confirmed that they seldom, if ever, complied with the requirement to provide information about the complaints and

only now developing a process to allow for representations to be made about decisions to include a child's name on the CPR. **The SSD must increase its efforts to ensure that the Complaints and Representations procedure is effective, and that there are separate and accessible ACPC procedures for service users to make representations about interagency child protection processes.**

Comprehensive Assessment

9

STRENGTHS	AREAS FOR DEVELOPMENT
• There was clear guidance about the completion of assessments. • The quality of assessments had improved since the introduction of APIR.	•There was poor interagency co-operation in carrying out assessments; particularly of adults who were allegedly dangerous to children. •A number of staff were not confident about how to plan assessments in a focused manner.

9.1 In the report of the previous inspection SSI made recommendations on the basis of our findings under these standards. The agencies' responses to the recommendations are set out below.

The Commissioning of Comprehensive Assessments

9.2 ***The Director of Social Services and senior managers must ensure that the ICPC is used to identify the nature and extent of the comprehensive assessment required for each child that is registered, and commissions appropriate staff to be involved in the work with the child and family members.***

9.3 Clear guidance was provided to staff on the completion of level 2 assessments (comprehensive assessments). Child protection conferences routinely required them to be undertaken when children were registered, and some were commissioned during the enquiry stage or when a case had been identified as concerning a child in need. Although we did not see many completed assessments as part of the inspection there were a significant number in the process of being done. We were confident that the new arrangements would lead to more assessments being completed and that they would be of a good standard. Where specialist assessment was required, for example where perpetrators of sexual abuse or those with mental disorders required a risk assessment as members of the same household, they had to be commissioned through other sources. The probation service and health trusts did not provide such assessments to social services, and accordingly they had to be bought from the independent sector. In one case, the SSD had agreed to fund the first year of an assessment of a schedule 1 offender, who then paid for the second year himself, with payment for the third year still to be determined. The probation service did have

powers to undertake such assessments when it was a condition of court proceedings, when it was a current case or in other exceptional circumstances, where resources allow.

9.4 Staff also complained that if they wanted to commission assessments from independent sources such as residential family centres or specialist facilities, there was a protracted application process in the SSD for finance which delayed the start of the work. **We considered that there needed to be clearer interagency arrangements for commissioning and contributing to comprehensive assessments.**

Co-ordinating Comprehensive Assessments

9.5 ***The Director of Social Services and senior managers must ensure that all key workers are trained in undertaking a comprehensive assessment.***

9.6 The majority of staff had received some form of guidance on the assessment of child protection cases and had received further guidance as part of the implementation of the APIR procedures. A series of helpful model assessments have been prepared by the Central Support Team (CST) to guide staff, and these were being refined in the light of experience. However, many of the staff we saw expressed some confusion about the amount of discretion they had to leave out certain parts of the assessment, as described in the procedures. They were therefore inclined to collect and evaluate rather more information than the circumstances of the case justified. **Some very helpful steps had been taken to implement this recommendation but the SSD needs to continue to support staff to produce assessments which are proportionate to the circumstances of the children and families concerned.**

9.7 ***The Director of Social Services and senior managers must ensure that progress in undertaking assessments is rigorously monitored by the child protection co-ordinator through the child protection review conference.***

9.8 In our examination of the case sample we noted that, where an assessment had been commissioned prior to the implementation of the APIR procedures in May 1998, there was a considerable variation in quality. Of the 26 commissioned, 10 had not been undertaken and there was no indication of the work beginning. **The SSD must be careful to ensure that the quality as well as the process of assessments continues to be monitored. This should be done not only through line management arrangements but through independent audit, and via the child protection co-ordinators in review conferences.**

Planning and Review

10

STRENGTHS	AREAS FOR DEVELOPMENT
• Social workers received good quality legal advice. • There had been investment in family support services in Fenland.	•Inquorate review conferences had been held. •Child protection plans were not routinely monitored by line managers. •There were inconsistent approaches to dealing with violent and unco-operative families.

10.1 In the report of the previous inspection SSI made recommendations on the basis of our findings under these standards. The agencies' responses to the recommendations are set out below.

The Completion of Child Protection Plans

10.2 ***The ACPC should ensure its procedures provide clear requirements for staff on the formulation, recording and implementation of child protection plans, based on the findings of initial and comprehensive assessments by core group members.***

10.3 The APIR procedures included clear guidance on structures for child protection plans, and the associated recording of core group meetings and assessments. Half of the cases in the sample had recognisable plans.

10.4 The child protection plans which arose from recently referred cases were of a better quality. Some social workers seemed unable to make a clear distinction between the child protection plan and the decisions and recommendations of an ICPC. This appeared to be a continuation of practice stemming from previous unclear guidance. Inspectors thought that if they were followed the new procedures were likely to improve the general quality of child protection plans. We considered it important that staff continually remind themselves that a child protection plan is not just about the production of a written statement, but is part of a dynamic process involving family members and other agencies in contributing to the plan and sharing ownership of it. **It is commendable that this recommendation has been satisfactorily implemented.**

Review of Plans

10.5 Child protection plans were reviewed by child protection conferences which were generally held within three or six months of the original conference. However, the problem of attendance at initial conferences happened with reviews as well. Therefore, a significant number of review conferences were postponed. This clearly caused difficulties for practitioners but more importantly left service users feeling disgruntled. In one case a social worker had spent a considerable amount of time and effort trying to engage a family in the child protection process. She had eventually succeeded in doing so only to discover that the review conference could not proceed because of a lack of attendance by other agencies. The family were naturally annoyed and upset, and felt that the lack of attendance at the conference indicated a lack of interest in them and their circumstances. We saw examples of review conferences being held when they were not quorate. This was clearly unacceptable and all agencies needed to remind their staff that it is not only those people who are involved in the core group who should attend conferences, but also the representatives of the agencies who were present at the initial conference. **We were concerned about this situation and considered that more work is required if this recommendation is to be satisfactorily implemented.**

Access to Legal Advice

10.6 ***Members should ensure that access to legal advice is reviewed so that it is available in all situations where the possibility of legal action needs to be considered.***

10.7 There was an inter-departmental protocol between social services and legal advisers which set out the conditions in which legal advice would be appropriately sought. All staff interviewed said they had ready access to legal advice and that it was of good quality. **The recommendation had been satisfactorily addressed, but we would however urge that attention be paid to our earlier comment about the more appropriate use of EPOs, police protection and Child Assessment Orders.**

The Deployment of Staff to Carry Out Child Protection Plans

10.8 ***Members should ensure that the formula for the distribution of resources across teams is examined to ensure it reflects demand as well as demography, once necessary work has been done to achieve a consistent baseline between teams.***

10.9 The SSD had taken steps to deploy staff more equitably across the authority. Some posts had been redeployed from the south of the county to the north. Senior managers had not gone as far as implementing the additional equity features in the staff deployment formula as this would have led to more changes than they believed could be coped with. In addition, the most recent restructuring (which will be referred to at a later stage in the report), had had the effect of creating ATM posts from the current establishment of senior practitioners. This was likely to have the effect, in our judgement, of reducing case holding capacity within every team, and team managers were uncertain as to how this under-capacity as they perceived it, would be managed. On the other hand senior managers were

more confident that the more direct supervision and guidance which the ATM posts would provide, would in time produce a more efficient throughput of cases, which would in turn result in a reduction of workload pressure.

10.10 The SSD had invested in family support services in Fenland through a partnership agreement with NCH - Action for Children, and through the deployment of family aides. For the more rural areas of the county it was also to provide outreach services from its family centres using family aides.

10.11 **Senior managers had taken steps to implement the recommendation but we considered that members needed to monitor the effectiveness of these arrangements and to continue to aim for equitable distribution of staff across the county.**

Confronting Hostile and Unco-operative Families

10.12 ***The Director of Social Services and senior managers must develop a strategy for dealing with hostile and unco-operative parents, with training provided.***

10.13 In its dealings with hostile and unco-operative families the SSD had not yet established an organisational culture in which staff could feel confident in confronting parents with their responsibilities, and ensuring the safety of the children. We saw some cases where the practice was worryingly poor, and where lack of insight by some managers had led to delays in matters being resolved, with continuing potential harm to the child. There were examples where the SSD had backed off in its demands on families, and where it had made alternative and weaker arrangements for monitoring the welfare of the children. In other cases, families had been advised by their own lawyers not to co-operate with the SSD where child protection concerns had been identified and we judged that this also compromised the safety of the children. In one case, it took a considerable amount of time for a resolution to be found in a situation where a social worker was being asked to supervise a family that were relatively near neighbours and who had made personal physical threats to her safety. The matter was finally resolved by the mutual transfer of this and another resistant family to another social work team, so they were managed by staff outside their home area. We considered that in some instances it is necessary for managers to take pragmatic and sensitive decisions to give staff the confidence that they are supported by them. However, we also saw some very good examples in teams which had taken an assertive approach to some aggressive families who were making personal threats to staff and managers.

10.14 The SSD was able to deploy a range of standard responses to support staff in dealing with difficult situations, including the provision of mobile phones, undertaking visits in pairs, and seeking the support of uniformed police. However, there was not a carefully thought out strategy which enabled the Department to respond routinely and supportively to staff in such circumstances. It was evident that staff did not have confidence in the ability or willingness of some managers or the organisation as a whole, to provide them with necessary back up and debriefing when required. **Some work had been done to address this concern and it was reflected in some of the cases, but there was a considerable amount of further work which the SSD needed to do if this recommendation was to be effectively implemented. Following this inspection the Director had begun to put in place a strategy to deal with this issue including the establishment of an arrangement to manage difficult cases and a system to support staff.**

Routine Monitoring of Plans in Case Records

10.15 ***The Director of Social Services and senior managers must ensure that managers monitor the initial response to child care referrals and the production and quality of plans.***

10.16 It was of concern that managers were still not routinely monitoring cases to ensure timely responses to referrals and to ensure the production of plans. There was a monitoring system in place whereby the team manager was required to check for procedural compliance, although this was not subject to any verification at more senior or even peer level. **We considered that the SSD needed to further improve its practice in this respect.**

Management

11

STRENGTHS	AREAS FOR DEVELOPMENT
• The listening style adopted by senior managers gave staff increased confidence in them. • Staff were regularly receiving satisfactory supervision. • Staff worked hard to achieve the objectives detailed in case plans, often by doing considerable amounts of extra hours. • Management information systems were being developed and more useful data sets were beginning to emerge.	•Cases were being held on duty pending the completion of assessments. •The action plan arising from the previous inspection had yet to be fully implemented. •Staff had not been sufficiently involved with the implementation of the plan and felt it had been rushed and ill considered. •The level and quality of the administrative support was inconsistent between teams.

11.1 In the report of the previous inspection SSI made recommendations on the basis of our findings under these standards. The agencies' responses to the recommendations are set out below.

The Structure of Children and Family Services

11.2 ***Members should ensure that the proposed child care specialist structure is implemented as quickly as possible.***

11.3 In response to the recommendations contained in the previous SSI report, early in 1998 the SSD had implemented a revised structure on the basis of twelve area teams, each led by a team manager. Senior practitioners within these teams were to undertake supervision of other staff for 50% of their working time. It quickly became apparent to the new Director on her appointment, that the structure was flawed. Staff had identified that the arrangements for supervision were unworkable, because senior practitioners were still holding cases which by their very nature and complexity took them away from supervisory activity.

11.4 As a consequence the Director and the new Assistant Director reviewed arrangements, and introduced a further revision to the structure. This was based on 9 teams, each led by a team manager, supported by more or fewer ATMs depending on the size of the team and its geographical location. In this way savings could be made in the amount of resource that was being used to provide duty cover in the Cambridge City and South Cambridgeshire teams, and a more effective intake and assessment process could be established throughout the county. It was also intended to make more use of team managers' time so that more energy could be put into monitoring and service development.

11.5 However, already concerns were being expressed by staff that the promotion of a number of senior practitioners to ATM posts was reducing the capacity to work with cases in teams. Senior managers' response to this has been detailed in previous chapters. Inspectors were concerned that the very fragility of the teams, and the lack of any contingency resources to support them or cover for long term absence, was likely to create problems in ensuring continuing services to all families that needed them. Already there were signs of cases being held in the duty system or not receiving an adequate level of assessment, and other cases being de-allocated from social workers' caseloads to make way for others that were perceived to have greater priority.

11.6 Inspectors considered that management below second tier level had become somewhat reactive and did not seem able to predict and manage potential difficulties before they arose. There was a culture of passing issues "up the line" to senior management without first exploring ways of resolving them locally.

11.7 In an effort to respond to concerns about this and to provide visible support to teams, the Director and Assistant Director had been active in encouraging staff to share such decisions about case allocation with them. Staff on the ground felt that this was a sign that senior managers were being supportive, and sharing difficult decisions and responsibility for cases with them. The Directorate had adopted this strategy in order to rebuild confidence in management and to set an example as to the kind of responses that staff should receive from managers lower down the hierarchy. The Director had also identified the need for more active management and so to ensure that difficulties arising from cases or staffing issues could be better responded to tactically on a local level. **Senior managers had taken vigorous steps to improve this situation and we considered that their proposals were likely to provide adequate long term solutions.**

The Implementation of the Action Plan

11.8 ***The Director of Social Services and senior managers must ensure that the task groups are adequately resourced to implement the SSD's action plan to time.***

11.9 ***The Director of Social Services and senior managers must ensure that staff are fully aware of the action plan and how the work of the task groups will be used to achieve the desired outcomes within an agreed timescale.***

11.10 ***The Director of Social Services and senior managers must develop a strategy for engaging staff in the changes deriving from the action plan, taking account of concerns arising from disciplinary actions taken against colleagues.***

11.11 Since the presentation of the previous inspection report to the Social Services Committee in November 1997, a great deal of management energy and member commitment had gone into ensuring that each element of the plan was being implemented. However we

considered that councillors needed continuing assistance to understand fully the complexity of the issues faced by the service. When the new Director realised the action plan was well behind schedule she advised the Chief Executive that some of the problems were very deep seated and would delay the pace of improvements. The overall effect of that was that they were not as far ahead with the developments in the child protection services as they would have wished. This was reflected in the case sample and from interviews with practitioners and case managers.

11.12 One consequence of this was that many staff complained that changes had come about in a last minute rush, prompted they believed, by the oncoming inspection. They said that all this had been difficult for them to absorb in the time available. It resulted in some loss of goodwill in relation to management, but staff were still hopeful that in the longer term changes at different management levels would ultimately result in improvements in the service.

11.13 There was little evidence of staff being involved in implementing the action plan through task groups, working parties or other mechanisms for consultation. The exception was the CST which we have discussed earlier in the report. We have also commented that the positive communications strategy had not been fully implemented. However, the staff newsletter and a system for keeping the Director informed of significant issues had been introduced. **Commendably these initiatives were beginning to have the effect of opening up the SSD to its own workforce. In addition the CST was to continue, with a changed remit, to support the implementation of the new structure and to continue to involve staff in further developments. We judged that the SSD was right to continue to exploit the effectiveness of the CST.**

Staff Supervision

11.14 ***The Director of Social Services and senior managers must ensure that the supervision policy is monitored by field care managers and that the frequency and content of supervision conforms to the SSD's requirements, and that supervision agreements have been completed by practice managers for all staff.***

11.15 The SSD had written procedural guidance for staff supervision. Almost all staff were receiving supervision regularly, but in some teams, the frequency had become variable because of pressures on team managers. The appointment of ATMs was likely to deal with this problem. Supervision was prioritised, with less experienced staff receiving it more frequently.

11.16 The overall picture was of competent supervision being offered, which was well regarded by staff. Some team managers were said to be better at providing case orientated supervision than addressing emotional support and staff training and development. Staff were supposed to receive an annual appraisal, but we were told that this rarely happened.

11.17 There was no evidence of a general use of supervision agreements between team managers and social workers although supervision was recorded, and an agenda was agreed between the participants prior to each session.

11.18 **The positive response to this recommendation was satisfactory overall, although more attention needed to be paid to ensure that all the requirements of the procedures for staff supervision were complied with.**

Workload Management

11.19 ***The Director of Social Services and senior managers must review the size of staff workloads, particularly those of senior practitioners, to ensure that they are manageable and do not include unnecessary administrative work.***

11.20 We were impressed with the way that staff worked hard to achieve the objectives which had been identified in the cases for which they were responsible, although we were told that this was often at considerable cost to their personal lives.

11.21 Although none of them said that their workload was impossible to manage, some said it was nearly so, and many staff reported working very long hours including weekends and late nights in order to prepare reports for child protection conferences, care proceedings and reviews. Workloads were not manageable, and this was reflected in the trend towards de-allocation of cases and cases waiting in the duty system. We were not suggesting that this was entirely due to the lack of resources deployed, as there may well have been efficiencies to be gained through better allocation practices, better decision making and interagency working.

11.22 The SSD had not introduced a workload management system yet but was considering implementing one in the longer term. Senior managers were studying options for this.

11.23 Although there was no management information available on sickness rates in teams, there was anecdotal evidence in some teams of quite high absence levels due to sickness. This contributed to the pressures on teams and the need for re-allocation and de-allocation of cases. At the time of the inspection, there were 13 child protection cases involving 25 children which did not have a named social worker, and of these 8 were on the CPR. However, this position may have been worse, because in teams team managers were actually nominated as key workers, although the monitoring of cases was being undertaken by other means, eg by schools or health visitors. SSD monitoring in these circumstances tended to be restricted to information gathered from core groups. **We considered that the SSD needed to undertake further work to improve the way it monitored workloads and other pressures on teams, but following this inspection the Director had already begun to address these matters.**

Administrative Support

11.24 There was inconsistency between teams in the levels and types of administrative support they received. In some cases, administrative staff undertook filing; in others this task was left to social workers. Some social workers word processed their own work, whereas in others they were typed by support staff. The administrative provision had not been reviewed following the restructuring and we considered that a review was indicated. The SSD should also provide guidance about the type and range of activities that should be undertaken by this group of staff. **In our judgement a review was required of the way in which administrative support was provided to fieldwork teams.**

Management Information

11.25 Work was being developed to improve the amount and quality of management information which the Social Services Information Database (SSID) provided. During the past six months extensive activity had gone into developing the capabilities of the system. Data was now beginning to emerge which was capable of being analysed. Work was also in hand on developing linkages between management information and the CPR and that deriving from level 1 and level 2 assessments.

11.26 From its management information the SSD had already identified a 50% increase in registrations in the last year, higher numbers of looked after children, and an increase in the number of care proceedings being taken. The SSD had set a target for reducing the number of looked after children by 10% in the year 1998/99. This group of children were responsible for considerable demands on the budget, particularly arising from the need to use expensive agency placements to supplement the SSD's own stock.

11.27 **The improving management information system was intended, in time, to help staff to sharpen their focus and decision making, to be more discriminating in the way referrals were assessed and prioritised, and to enhance the gatekeeping arrangements. As familiarity with the APIR system improves, senior managers anticipate that workloads will become more manageable. They recognise that the SSD has still some way to go before its services for children in need and child protection can be enhanced by better management information.**

Record Keeping

12

STRENGTHS	AREAS FOR DEVELOPMENT
• The case file format facilitated access to information. • APIR had introduced helpful formats for recording agency checks and strategy discussions. • Level 1 assessments were, on the whole, reaching the right conclusions. • Child protection records were typed.	•There was little evidence of managers signing records of decisions or monitoring for quality. •Level 2 assessments lacked sufficient analysis. •Staff were having to compile information repetitiously and in an over-complicated way. •Staff did not receive enough training or guidance about how and what to record.

12.1 In the report of the previous inspection SSI made recommendations on the basis of our findings under these standards. The agencies' responses to the recommendations are set out below.

The Quality of Case Records

12.2 ***The Director of Social Services and senior managers must develop a policy on recording supported by operational instructions which should cover:***

- ***information obtained from initial enquiries of other agencies;***
- ***strategy discussions;***
- ***practice managers' decisions to proceed with the investigation;***
- ***evaluation;***
- ***outcome of investigation;***
- ***decisions in supervision;***

- ***auditing arrangements;***

- ***organisation of files; and***

- ***legibility of records.***

12.3 We judged that 15 of the 36 case records that we studied were of a good standard, the rest being weak or poor. Interviews with social workers confirmed that checks with other agencies were done but they were not always well recorded on the file. The newly introduced checklist as part of the APIR procedures was already providing a better system for this. Although contacts with other agencies were recorded there was no record of a strategy discussion. Again a new form has been introduced which provides for more consistency. 11 records of child protection work were typed.

12.4 Of 35 initial assessments in the case samples, 23 were judged to be good and 3 were poor. It was difficult to identify the outcome of enquiries from the older case files but the new procedures were better at drawing out this information. Records of decisions from case supervision were contained in a separate supervision record and seldom got onto the child's case file. There was no evidence of managers signing to endorse decisions to proceed to enquiries, or of them auditing the records for procedural compliance. The format of case files consistently followed SSD guidance although we were concerned that there was no section for third party information.

Analysis of Information

12.5 An audit of the effectiveness of the APIR system had been undertaken by an independent consultant in July 1998. This concluded that, although the procedures were being followed, the quality of the analysis of the data which was compiled was poor. Our reading of the case records confirmed this view and it was endorsed by senior managers in our discussions with them. There was a clear need for more training for staff in evaluating information before them, and being discriminating about what kinds of information needed to be included in particular cases.

The Content of Case Records

12.6 The way staff were compiling case records led to considerable duplication of information. They complained of having to repeat it in several different forms in several different places and for different audiences. We found a considerable proportion of the case records quite difficult to understand because of this, and we were concerned that the opportunity had not been taken to revise the guidance on case recording to support the implementation of the new procedures. As it stood, the APIR procedures had been imposed on top of existing requirements and social workers claimed, with some justification in our view, that they had simply added to their already demanding workloads. We would urge the SSD to set about resolving this as soon as possible, in order to achieve an efficient and economical method of recording.

12.7 Staff had not received recent training in case recording but procedures for recording were already in place, although current practice guidance needed to be reviewed. Training on

recording had been provided for staff in provider units in the last year but nothing about case records per se was included in the 1998/99 training plan beyond what would be included in the courses about practices and procedures in relation to APIR. This was a concern to us, especially in the light of the findings of this and the previous inspection. There needs to be a greater emphasis on house style and recording techniques to assist staff to become more concise and informative in their written work.

12.8 Overall the response to this recommendation had not been sufficient to ensure that case records were yet of a satisfactory standard.

Policy

13

STRENGTHS	AREAS FOR DEVELOPMENT
• The SSD's child protection procedures complied with current guidance.	•The late appointment of the Child Protection and Review Co-ordinator may have delayed the introduction of key elements of the child protection logistical framework.

13.1 In the report of the previous inspection SSI made recommendations on the basis of our findings under these standards. The agencies' responses to the recommendations are set out below.

Child Protection Policy

13.2 ***Members should ensure a child protection policy is agreed based on the work of the Practice Guide Project.***

13.3 The SSD and ACPC policies were contained within the mission statement and core values of the new procedures. It was also contained within the interagency Childrens' Services Plan (CSP). The CSP placed considerable emphasis on the refocusing of child protection into family support services, and this was reflected in the interagency and SSD procedures. The child protection policy had been agreed by the SSC and endorsed by the County Council.

13.4 As reported previously the SSD had introduced a new set of interagency procedures for children in need and child protection work on the 5 May 1998. Implementation of these procedures had been undertaken by a process of training for all the teams on the draft version, supplemented by the CST of developmental staff visiting individual teams to consult on their effectiveness and usefulness of the procedures. Members of the CST had also spent time with duty officers working through procedures, and identifying and remedying weaknesses when they became evident in practice.

13.5 The APIR system had not been introduced as early as the SSD had hoped. While we regarded the system as well conceived and introduced with appropriate support and training, its effects had not worked their way through the majority of cases which had been active in the teams prior to their introduction. Where cases had been referred after the implementation date, the value of the procedures was clear. However, staff told us that they

were having difficulty getting beyond the need to meet procedural requirements, and had not yet understood what the scope of their work should include in different cases. For example, many of the social workers and team managers that we saw were not aware that level 2 assessments did not necessarily have to include all those components described in the procedures, in order to produce a competent assessment.

13.6 **In our judgement there is still more work to be done by SSD managers to ensure that staff are not only complying with procedures, but fully understand them.**

Policy and Practice Adviser for Child Protection

13.7 ***Members should ensure a policy and practice adviser for child protection is appointed to the policy development team at headquarters.***

13.8 A Child Protection and Review Co-ordinator had been appointed in April 1998 to oversee the work of the child protection co-ordinators and the independent reviewing officers responsible for reviewing looked after children. We were surprised that this key appointment had not been made earlier, given its importance in developing and planning how procedures would be applied from the outset. At the time of the inspection there were still many crucial systems that needed to be put into place within the Child Protection Service, such as monitoring and audit systems, and the production of management information. In addition work was still being done by the co-ordinator in relocating staff and securing appropriate accommodation for them.

13.9 We were informed that most of this manager's energy had been taken up in sorting out the logistics of the child protection and review service, particularly in relation to physical location, administrative support and information systems. **We considered that valuable time had been lost because of the relatively late appointment of the Child Protection and Review Co-ordinator. Senior managers should consider how they might assist the co-ordinator to become more actively engaged in quality monitoring and assurance.**

Interagency Policy and Procedures

14

STRENGTHS	AREAS FOR DEVELOPMENT
• The current structure of the ACPC was working well. • Interagency relationships were improved. • Shared sub-committees with Peterborough helped interagency consistency. • The ACPC had an agreed budget. • The appointment of a Staff Officer to the ACPC has helped in moving the business forward.	•The progress in the ACPC had yet to make an impact on the day-to-day interagency work. •There was concern about the level and seniority of SSD representation. •There was still a lack of commitment from some members of staff in partner agencies to interagency child protection work.

14.1 In the report of the previous inspection SSI made recommendations on the basis of our findings under these standards. The agencies' responses to the recommendations are set out below.

The Area Child Protection Committee

14.2 ***The ACPC should review its purpose, role, function, membership and the way it conducts its business to become more effective in shaping interagency policy and procedures and interagency collaboration in child protection services.***

14.3 The Cambridgeshire Child Protection Committee was reconstituted in April 1998 following the disaggregation of the old county. Separate child protection committees were established for each authority. The establishment of the new ACPC brought with it a review of membership, the appointment of an independent Chair, and a revised set of interagency procedures. The SSD had established five sub-committees, dealing with standards, training, practice development and research, procedures, and communications. There were also two practice forums based on localities, one in the north and one in the south of the county. The sub-committees were chaired by key members of the main committee and the practice forums were chaired by child protection co-ordinators.

14.4 The ACPC had established clear terms of reference for itself and for its sub-committees,

and had an established series of quarterly meetings, with its sub-committees scheduled to meet between times. Each sub-committee reported to the Chair and Staff Officer for the ACPC via the notes of its meeting as well as formally reporting to the ACPC on a regular basis. Therefore, the work of all these groups was monitored and co-ordinated.

14.5 The ACPC had developed a detailed work programme delegated to each of its sub-committees, based upon the recommendations contained in the report into child protection services conducted by the Bridge Consultancy Service in 1996, and on SSI's own report of its inspection in 1997. Some of the items in the work programme had individual timescales for completion but others did not. Although work was progressing on all the items in the work programme, only four had been completed by the time of the inspection. A number of others were due to be finalised by December 1998 with the remainder scheduled for June 1999 or not having any particular reporting date noted.

14.6 We were concerned that, as in other aspects of the implementation of the action plan, less progress had been made by the ACPC than we would have expected, on account of its late re-establishment. However, we do accept that it was logical for it to be delayed until April 1998 to coincide with LGR and all the other disaggregation issues which that brought with it.

Functioning of the ACPC

14.7 Without reservation all the agency representatives that we interviewed, and the Chair of the ACPC, spoke highly of the way that the new Committee had gone about establishing itself and conducting its business. Working relations were good and all spoke positively of the efficiency of the way the business was done. The support of the Staff Officer was a key element in progressing agenda items, and ensuring continuity of work between meetings.

14.8 Although members felt that the new structure was working well, some were concerned that the SSD was represented at too senior a level (the Director of Social Services and two Assistant Directors). We considered that it might be useful for the SSD to rethink its level of representation and after the inspection the number of SSD staff on the ACPC was reduced to two, the Director and the Assistant Director (Children).

14.9 Although member agencies were working well within the ACPC, we have noted earlier that operationally arrangements were less well secured. There was a need for the training and re-education of some key professionals in the child protection process to enable effective child protection services to be delivered everywhere in the county. This was particularly true among some paediatricians, some general practitioners and some schools.

14.10 The ACPC had agreed a budget in principle last year which came into effect at the beginning of this financial year. The formula had been devised where a budget of £90,000 had been agreed, with the SSD and the police contributing 27.5% each, the two health authorities contributing 25% between them, probation contributing 5%, and the education department contributing 15%. This budget was to pay for the ACPC Staff Officer, up to a full time post, although the current incumbent was only carrying out these duties on a part time basis, funded by the SSD. It was also designed to fund a full time interagency child protection training officer, currently being employed by the SSD and undertaking the bulk of her responsibilities for the SSD. It was also intended to provide money for a publicity budget and a part time administrative post.

14.11 **We considered that a commendably good start had been made in re-establishing the ACPC. Planned developments for the future were the establishment of an interagency budget, the appointment of an interagency trainer, and publication of an ACPC newsletter to better inform the public and other agency staff about the work.**

The Conduct and Follow-up of Reviews under Part 8 of Working Together

14.12 ***The ACPC should take a fuller part in the commissioning of Part 8 reviews and in monitoring the implementation of report recommendations.***

14.13 Part 8 reviews, conducted by the procedure of appointing a case review committee, were somewhat confusing. The ACPC procedures stated that the ACPC Chair will "have a standing ACPC case review sub-committee to prepare an overview report". However, the terms of reference of the standards sub-committee made it clear that it was responsible for carrying them out. It would be helpful if the ACPC were to clarify its position in this respect. Otherwise the procedures for Part 8 reviews were satisfactory, stipulating the membership of the review sub-committee, the timescales, how the work was to be carried out, and the responsibilities of individual agencies. It described a report format and the action which the ACPC should take following the submission of an overview report.

14.14 At the time of the inspection there were four Part 8 reviews being undertaken, two of which were completed while the inspection team was in the Authority. These two had been conducted jointly with Peterborough Child Protection Committee, as the events that gave rise to them had arisen prior to LGR. Therefore, both committees took responsibility for analysing where the deficits in the cases might have lain, and for taking future action to amend procedures. Two more recent cases had occurred in the county of Cambridge and the reports were still in the process of completion. From the information presented to Inspectors it was likely that each of the completed reviews had considerable implications for the agencies involved, having similarities with earlier cases. The ACPC and the SSD were mindful of these matters and were taking steps to address them. Three of the incidents had occurred prior to the implementation of the new procedures and one had happened more recently. **We were satisfied that the work undertaken would ensure that the current procedures for reviewing such cases were satisfactory. There were adequate mechanisms to ensure that recommendations arising out of Part 8 reviews would be implemented, included in procedures, and their implementation reviewed.**

14.15 The current state of the ACPC was well described by the Chair as being conducted in "a good atmosphere, with good will but still a huge amount to do."

Staff Competence and Deployment

15

STRENGTHS	AREAS FOR DEVELOPMENT
• Child protection competencies were contained in the training plan. • All staff undertaking child protection work had received the appropriate basic training. • The joint implementation training was considered to be effective.	•There needed to be a more systematic approach to the auditing of training needs. •The SSD needed to ensure that all annual appraisals were being carried out. •The joint enquiry training was difficult for part-time staff to access.

15.1 In the report of the previous inspection SSI made recommendations on the basis of our findings under these standards. The agencies' responses to the recommendations are set out below.

The Competencies Required for Child Protection Work

15.2 ***The Director and senior managers must develop an SSD training programme based on the competencies required for child protection work and staff's individual training plans.***

15.3 The SSD training plan did not appear to derive directly from a systematic annual training audit. However there was an "annual development day" in which managers and trainers came together to form a view about the training needs of staff arising from organisational developments, and knowledge reported from supervision. There were also "training pathways" which staff undertook as part of their professional development on joining the department. These progressed from basic training courses, such as recognition of child protection issues, through to more complex and competency based courses such as joint enquiry training, communicating with children and court skills.

15.4 The core competencies for child protection were contained within the child protection training programmes. There was an extensive amount of training provided at the basic level for staff, but senior practitioners and more experienced staff frequently complained that training was not available for them which extended their knowledge and skills. There were however exceptional opportunities for staff to undertake extensive training externally,

at the local university or, for example, at the UEA or the Tavistock Institute. These were usually funded by the SSD, although individual members of staff had to find time within their work schedule to enable them to take part. However, we did see a number of people who had taken up these training opportunities and were pursuing them with enthusiasm. **The implementation of this recommendation has been satisfactory so far although we judged that the training programme would be enhanced by being informed by a systematic audit of individual staff training needs.**

The Quality and Content of Training

15.5 ***The Director and senior managers must ensure that all staff who require essential training in child protection receive it, and monitor the take up of training to ensure that it receives its proper priority.***

15.6 ***The Director and senior managers must ensure that all training is evaluated and that it is of the required standard and meets staff's needs.***

(For details of staff experience and of the training they have received please see Appendix D.)

15.7 All staff undertaking child protection work had received the appropriate training. For some this was not recent as they had been employed for many years within the SSD. Particularly noteworthy was the fact that the joint enquiry training with the police was regarded highly although some staff, who work part-time, complained that they were unable to take advantage of it because it was a lengthy course (10 days). It would actually keep them away from duty for a month if they were to take part in it and claim their owed time back.

15.8 Managers indicated a lack of management development training for them, although there were indications from the training programme that this was developing. Inspectors were aware of the longstanding programme of MESOL training which had been available within the authority for many years.

15.9 The quality and content of training courses was evaluated through the usual exit questionnaires, and some trainers evaluated the training courses of others, but there did not appear to be any quality audit beyond this. As part of the process of developing managers' skills, the Director was engaging team managers and operational managers in action learning sets and the SSD was part of the Research in Practice project being led by Bristol University's Dartington Research Unit. In this way it was hoped to develop their management skills.

15.10 Before undertaking child protection enquiries staff were required to undertake a minimum of post qualification service, and to have done basic child protection courses including joint investigation training with the police. There was no further assessment of their competence beyond this other than the judgement of their line manager. We judged that the SSD should consider whether, in the longer term, some post qualification accreditation in child protection work would be appropriate for the staff undertaking Section 47 enquiries, and the supervision of vulnerable children on the CPR.

The Deployment of Staff

15.11 Following the restructuring the decision had been taken to freeze the number of senior practitioner posts at its present level. Any further recruitment of social workers would not provide the opportunity to advance to senior practitioner grade. However, staff currently in post would be eligible for this progression which was decided upon on the basis of written submissions and the assessment of the team manager. Inspectors were unable to get a clear indication of the number of senior practitioners and their deployment across teams. As far as we were able to judge there were no plans for the equalisation of these experienced staff from stronger to weaker teams, and this was particularly worrying in the light of the appointment of some of them to the posts of ATMs.

Operation of the Child Protection Register
16

STRENGTHS	AREAS FOR DEVELOPMENT
	•Clearer guidance was required to ensure register checks were properly made. •There was evidence in the case sample, and in Part 8 reviews, of staff in different agencies not consulting the CPR.

16.1 In the report of the previous inspection SSI made recommendations on the basis of our findings under these standards. The agencies' responses to the recommendations are set out below.

Operation of the Register

16.2 ***The ACPC should ensure that all relevant staff from the SSD and other agencies can obtain access to the register.***

16.3 Although some claimed that enquiries could by-pass the register, senior managers were satisfied that an enquiry of the CPR via the Client index/SSID cannot be made. In their view, the case file on SSID would show that a child is on the register but would not give details of registration category. Changes to the Register could only be made by staff in the Child Protection and Review Unit (PRU). No other staff could do this. It could not be done via the Client index/SSID.

16.4 They accepted that there did need to be more protocols governing the difference between a Register Enquiry (this could only be made via CPRU and was therefore logged as an enquiry), and simply accessing a case file and noticing that the case is starred as being on the Register. It was accepted that staff needed better instructions on this but would wish to retain a situation where a child's computerised case file shows that the child is on the register. They needed to be clear that this did not constitute a proper check on the register.

16.5 We were concerned to see that in some of the cases in the sample, and in Part 8 reviews which we studied, that staff in hospital A&E departments failed to consult the register when a child had been presented with injuries on a second and subsequent occasion. This had occurred both during the day and at night. While an injury must be seen in the context of

other indicators of abuse and neglect, it may be a significant indicator in its own right, and too much reliance should not be placed on the carer's account of how the injury had occurred. Checking the register is one way of establishing whether other indicators may be present. The ACPC should satisfy itself that A&E staff are aware of indicators of abuse and neglect, know when and how to raise concerns, and be familiar with local procedures for checking the CPR.

Standards and Criteria

APPENDIX A

A. DIMENSIONS OF PERFORMANCE IN CASE INVESTIGATION AND MANAGEMENT

1. RECOGNITION AND REFERRAL

STANDARD 1

The SSD publishes advice for the general public, professionals and anyone caring for a child, indicating who to contact if they have concerns about a child being abused or harmed.

CRITERIA

1. The SSD publishes advice about who to contact when a child is thought to be or is at risk of suffering significant harm.

2. The advice is clearly written in a style, language and medium which ensures that the information is accessible to children, anyone caring for a child and members of the general public.

STANDARD 2

All SSD professionals, administrative staff and carers who work with children and families are alert to the signs of child abuse and know how to respond to them to ensure the protection of children.

CRITERIA

1. All staff and carers are given training in the recognition of abuse and how to assess the need to protect children.

2. All staff and carers are given training in how to respond to signs or indicators of abuse in a manner which ensures that the referred child is protected.

3. In situations where there are child protection concerns, staff and carers refer children to the social work team with responsibility for child protection work.

STANDARD 3

All SSD staff involved in deciding upon action in relation to a referral have the necessary training, skills and expertise.

CRITERIA

1. The SSD has staff at key access points to the department, with the skills and expertise necessary to identify and manage child protection referrals and make competent decisions about future actions which result in the protection of children.

2. All referrals are taken seriously.

3. The SSD provides appropriate training and guidance to ensure all staff who have responsibility for deciding how to act on a referral, continue to be competent to do so.

STANDARD 4

People who have referred an incident of suspected child abuse or a concern are contacted and told as far as possible, within the bounds of confidentiality, what action has been taken.

CRITERIA

1. Procedures confirm the need to inform people (within the bounds of confidentiality) of the action taken following receipt of their referral of a suspected child abuse situation.

2. People who have referred children are appropriately informed of the action taken by the SSD.

2. IMMEDIATE PROTECTION AND IDENTIFYING THE NATURE OF THE CONCERN

STANDARD 5

There are SSD procedures detailing the initial response to a child protection referral required by all the respective agencies, including the SSD. Other than in cases of extreme urgency where immediate protective action is required, referrals are discussed with other professionals from child protection agencies, and with the referrer.

CRITERIA

1. The procedures require SSD staff to act promptly in response to a child protection referral.

2. The SSD's procedures detail how staff in the respective agencies, including the SSD, are required to respond to a child protection referral.

3. The SSD's procedures specify:

    - In cases of extreme urgency requiring immediate protective action, referrals are discussed with other professionals from child protection agencies and with the referrer, as soon as practicable after the child's safety has been secured.

    - Referrals are discussed with other professionals from child protection agencies and with the referrer to identify and define the nature and extent of the concerns.

STANDARD 6

There are procedures outlining the steps which need to be taken to ensure the immediate protection of the child/children where necessary. These are implemented in practice.

CRITERIA

1. The procedures set out the legal and practical steps that can be taken to protect all children in a household.

2. Rapid decisions are made to protect the child/children in situations where they are at risk or there is the likelihood of serious injury.

3. Where possible, arrangements are made for the abuser to be removed from the household.

4. The child is only removed from their place of residence if it is not safe for them to remain living there.
5. When appropriate, the child's wishes are ascertained and taken into account in the decision making process.

6. If the child is moved from their home, contact with parents, carers and other family

members is arranged according to the interests of the child. Families are given appropriate information, in writing, about these arrangements.

7. All those with parental responsibility participate in the decision.

STANDARD 7

Following receipt of a child protection referral, sufficient information is gathered about the child and family to enable a decision to be made about whether to proceed to the next stage in the process.

CRITERIA

1. Checks with the local authority's child protection register and police are undertaken.

2. The local authority's case records index is checked.

3. Consultation takes place with those professionals and agencies who are either in direct contact with, or have information about, the family.

4. Within a timescale which ensures the protection of the referred child, a designated manager takes account of all the information which has been gathered, and decides whether to proceed to the next stage.

STANDARD 8

Following a decision to proceed with the child protection process, the SSD staff identify the nature of the concern about a child.

CRITERIA

1. In cases of extreme urgency requiring immediate protective action, referrals are discussed with other professionals from child protection agencies and with the referrer, as soon as practicable after the child's safety has been secured.

2. Referrals are discussed with other professionals from child protection agencies and with the referrer to identify and define the nature and extent of the concerns.

3. The professional staff, including a designated manager, consider the known information and decide whether there is a need for: immediate protection; the convening of a strategy meeting; specific professionals to undertake further work to gain sufficient information to enable decisions to be made about the risks to the child; identified services to be offered to the child and family; no further action.

4. A decision of no further action is reviewed at an appropriate managerial level, at the earliest opportunity. The manager records the outcome of this review on the referral sheet in the case file.

STANDARD 9

When an investigation under Section 47 of the Children Act is being considered, an early strategy discussion, initiated by the agency receiving the referral, takes place between the relevant agencies (for example SSD and police). It considers all the known information about the child or family, and when appropriate, plans the extent and nature of any investigation, specifying the role of each agency.

CRITERIA

1. When appropriate, the agency receiving the referral initiates a strategy discussion quickly, involving the relevant agencies.

2. Those participating in strategy discussions consider all known information about the child and family and when appropriate, devise an investigation plan, which specifies the role of each agency, and the extent and nature of an investigation.

3. The decisions made at a strategy discussion are recorded in the child's file.

4. As part of the departmental system for collecting data on child protection work the frequency, reason for and outcomes of strategy discussions are monitored.

STANDARD 10

All decisions on action to be taken, including where no formal investigation is to be undertaken, are made at an agreed management level and within an agreed timescale. These are recorded on the case file.

CRITERIA

1. Decisions about action to be taken are made by a social worker in consultation with his/her line manager or a manager with delegated responsibility for the management of that social worker.

2. All decisions are made without undue delay, within an agreed timescale.

3. Delays that have occurred in making the final decision are justified in terms of the child's best interests. The decision, and its justification, are recorded on the case file.

4. Wh

- takes account of the child's race, religion, language, gender, and any special needs in formulating an initial plan.

STANDARD 12

The investigation is focused on the needs of the child and is conducted at a pace and in a manner appropriate to the child's age and understanding. Written records of interview are contemporaneous. The appropriate people are informed in writing about the outcome of the investigation including when no cause for concern was revealed.

CRITERIA

1. Throughout the investigative process, the social worker maintains an open mind, engages when appropriate with others and gathers evidence to ascertain whether or not abuse has occurred.

2. The number of investigative interviews or examinations of the child is kept to the minimum necessary to understand the child's situation.

3. During the investigative interviews the child is helped to relax and feel at ease. Consideration is given to having an appropriate parent/carer, relative, friend or supporter present during the interviews.

4. The interviewer listens carefully to what the child has to say and communicates with them in a responsive and receptive manner.

5. The interviewer works at the child's pace, using language (with the assistance of an interpreter if necessary) or a means of communication the child can understand and enables the child to talk about and give a clear account of the events which were the source of concern.

6. The interviewer is open to the possibility that the events, which had resulted in the referral, have not taken place.

7. The recording of interviews is accurate and differentiates between fact, hearsay and opinion.

8. SSD procedures address the issues arising from `Memorandum of Good Practice: On Video Recorded Interviews with Child Witnesses for Criminal Proceedings' The Home Office in conjunction with the Department of Health, 1992, (Criminal Justice Act, 1991).

9. If the investigation is part of the assessment in the course of Court proceedings, the Court's prior agreement should be sought for examinations being carried out for the purposes of expert evidence.

10. Parents (or anyone with parental responsibility), the child (if of sufficient age and understanding) and referrer, as appropriate, are informed in person and in writing about the outcome of the investigation including those that revealed no substance to the cause for concern.

4. DECISION MAKING ABOUT REGISTRATION AT CHILD PROTECTION CONFERENCES

STANDARD 13:

Child protection conferences are convened and conducted in accordance with the guidance in "Working Together Under The Children Act 1989" (1991).

CRITERIA

1. Initial child protection conferences are called only after an investigation under Section 47 of the Children Act 1989 has been made in response to the referral of an incident or suspicion of abuse and relevant information and reports are available.

2. SSD procedures clearly set out the functions and tasks of initial child protection conferences, including membership and process.

3. The initial conference is held within eight working days of the referral being received by the statutory agency (that is the SSD or the NSPCC).

4. Any reasons for a delay in holding the child protection conference up to a maximum 15 days from the date of referral are clearly recorded.

5. Initial child protection conferences are chaired by a member of the SSD or NSPCC's staff, who has not had line management responsibility for the case, and who has knowledge and expertise in the child protection field and skills in chairing conferences.

6. Initial child protection conferences are held at a time and place which suits families and carers, as well as professionals.

7. The conferences are attended by a representative from all the agencies which have specific responsibilities in the child protection process; if representatives cannot attend, their written responses are tabled.

8. The conferences are attended by a representative from all agencies which have had a particular involvement with the child/or family and others, such as foster carers, who have a contribution to make, taking account of the imperatives of efficiency and confidentiality.

9. Parents and children who attend child protection conferences are well prepared about how it will be managed, how they can contribute at all stages in the process, and briefed on the issues which will be discussed.

10. The chair meets, in advance of the conference, with parents and children who are planning to attend.

11. Initial child protection conferences share and evaluate information, identify concerns, determine levels of risk to the child or children, and decide on the need for registration.

12. Initial child protection conferences discuss and record a proposed plan of action for work with the child and their family, carers and others.

13. Dates for the core group to review the child protection plan are set.

14. Initial child protection conferences appoint a named key worker, from either the SSD or NSPCC, for the registered child.

15. Initial child protection conferences make recommendations to be carried out by a core group of professionals from relevant agencies.

16. There is a locally agreed procedure for ensuring initial child protection conference recommendations are acted on.

17. A review date for the next conference is made.

18. Following initial child protection conferences, written minutes setting out the essential facts, decisions and recommendations, the interagency child protection plan and an account of the discussion are completed and dispatched quickly to everyone attending the conference.

19. Where the parents and child did not attend an initial conference, a summary of the decisions and interagency child protection plan is given to them.

20. A decision not to register is communicated to the parents and if appropriate the child, in writing by the chair of the conference, even if the parents and child were present at the conference.

21. There is a management system for monitoring the quality of decision making, involvement of families and attendance by appropriate professionals at initial child protection conferences.

5. COMPREHENSIVE ASSESSMENT

STANDARD 14

A comprehensive assessment of the child and family's situation, which includes contributions from other agencies, is undertaken when a child's name is placed on the Child Protection Register. This assessment informs the child protection plan. Assessment is a continuing activity throughout the child protection process.

CRITERIA

1. Arrangements for a comprehensive assessment are made as part of the child protection plan. They include being clear about the purpose of the assessment, deciding who will be responsible for each aspect of the assessment and timescales for carrying it out.

2. A named key worker co-ordinates the comprehensive assessment.

3. The comprehensive assessment is carried out in a structured way with the involvement of other agencies, the child, family, carers and significant others in the child's life.

4. The child is seen on their own, and interacting with their parents, other relevant family members and carers.

5. Those with parental responsibility, relevant family members and carers are seen on their own and together, as appropriate.

6. The assessment includes contributions from other agencies to cover the child's social, health, education, developmental and environmental circumstances; also those of relevant family members.

7. The comprehensive assessment provides a full understanding of the child's needs and their family situation, their patterns of behaviour, the nature of interactions and family roles, the name of the cause(s) for concern about the child, and level of future risk to the child in order to provide a sound basis for decisions about future actions.

8. The comprehensive assessment informs the child protection plan both when it is constructed and when it is revised.

9. Where it is not possible for a child to be safely and/or adequately cared for within their own family or where this is not achievable within an appropriate timescale, it is recommended that plans are made to provide satisfactory, permanent, substitute arrangements for the child.

10. Detailed records of the information collected, including observations and the opinions and views of assessors are kept. The findings are summarised, and conclusions from the assessment process are clearly recorded. Judgements are made about the feasibility and likely timescales for achieving the required changes in the family or in it's circumstances. Detailed recommendations specify necessary future actions and the resources needed to achieve these objectives.

11. Assessment and re-assessment of the child and family's situation are ongoing throughout the child protection process.

6. PLANNING

STANDARD 15

A written child protection plan is constructed with the involvement of the child, the child's parents/carers and relevant agencies. The initial child protection plan is revised when developments take place and crises arise.

CRITERIA

1. A written child protection plan is drawn up for every child whose name is on the Child Protection Register.

2. The primary purpose of the plan is to ensure that the child is protected, and then to promote

possible, the plans specify clear and measurable objectives for change which can be used to evaluate progress.

4. The plan sets out the services to be offered to the child, family members and carers by each agency taking account of each agency's statutory duties, and reflecting contemporary methods of good inter-disciplinary practice. The plan specifies who in the agency will undertake specific pieces of work and sets out timescales for each of these.

5. The plan takes account of local resources and the suitability and availability of specialist facilities, including those not in the local area.

6. The individual agencies take responsibility for implementing those parts of the plan which relate to them.

7. The child, those with parental responsibility and significant others in the child's life contribute to the development of the plan.

8. The child and parents are given clear information about the purpose and nature of the plan, the expectations any agencies have of the part to be played by the child and family, and the expectations that the child and parents should have of each agency involved.

9. The child and parents are given a written copy of the child protection plan, and any disagreements about the plan are recorded.

10. The child protection plan is reviewed when unexpected developments or crises arise.

STANDARD 16

All aspects of the child protection plan are implemented, unless changes are made based on a re-assessment of the child and family's circumstances.

CRITERIA

1. Negotiations about how the plan will be implemented take palce with the parents and child, and are confirmed in writing.

2. The named key worker seeks specialist advice, as necessary, from the core group and other sources such as consultants with expertise in child care/child protection, in order to carry out their professional work with the child and family.

3. Regular reviews of the work undertaken with the child and the family members are held and the effectiveness of the current plan evaluated. The revised plan is agreed at the child protection conference.

4. Planned timescales are achieved.

5. The objectives of the plan are achieved and this is recorded.

6. The reasons for any objectives not being achieved or only partially being achieved are recorded and are justifiable.

7. There is systematic monitoring of the implementation of the agreed plan.

STANDARD 17

The interagency child protection plan is reviewed regularly at a review conference which is held at minimum intervals of six months.

CRITERIA

1. Review conferences are held at least every six months, or more frequently if requested by other professionals, or if the circumstances of the child demand it (eg where the child is thought to be inadequately protected or there is a need to change the child protection plan).

2. If child protection review conferences and other types of reviews are combined, a clear distinction needs to be made between the decisions of each type of conference.

3. The child protection review conference reviews the arrangements for the protection of the child, examines the current level of risk, ensures that the child continues to be adequately protected, considers the interagency work of the core group, reviews the child protection plan and considers whether registration should continue or end.

4. Parents and children (where appropriate) are invited to attend review child protection conferences, unless there are justifiable reasons for them to be excluded for the whole or part of the conference.

5. Where parents and children are not invited to attend review conferences, they are informed of this decision in writing.

6. The content, decisions and recommendations of child protection review conferences and other statutory reviews are recorded separately.

7. Following child protection review conferences, written minutes setting out the essential facts, decisions, recommendations, the interagency child protection plan and an account of the discussion, are completed and dispatched quickly to everyone attending the conference.

8. Where the child and parents did not attend a review conference, a summary of the decisions and child protection plan is given to them.

STANDARD 18

De-registration is the outcome of the child protection review conference only when all participants are satisfied that the abuse or risk of abuse is no longer present or sufficient to warrant continued registration.

CRITERIA

1. The child's parents/carers are informed about the process of de-registration.

2. Arrangements are in place for differences of opinion between participants to be managed constructively, primarily by the Conference Chair.

3. Any dissenting views or disagreements with the decision to de-register the child's name are recorded in the review conference minutes.

4. Decisions to de-register the child's name are accompanied by consideration of the continuing need for services to the child and family.

5. The child's parents/carers are informed in person, if possible, and in writing of the decision to de-register the child's name from the Child Protection Register.

7. MANAGEMENT

STANDARD 19

The SSD has clear structures for the management of and accountability for all staff undertaking child protection work, whether in field, day or residential services.

CRITERIA

1. There are systems for determining and monitoring workloads, prioritising work and allocating it to staff, avoiding overload of individual staff or particular teams or units.

2. There is clarity about the level of decision making, particularly the level of delegated responsibility at each tier of management.

3. There is a system which enables decisions to be taken at a higher management level when

STANDARD 20

The SSD has a management information system for child protection services.

CRITERIA

1. There is a management information system for collecting and collating, analysing and interpreting information on child protection services.

2. Managers of child protection services have access to information on overall demand and its differential nature.

3. Information is available about expenditure on child protection services.

4. Managers are able to evaluate the performance of a service in relation to response times, throughput and output.

STANDARD 21

The SSD has quality control systems for child protection work.

CRITERIA

1. Within the SSD, specific managerial posts have clearly defined responsibilities for monitoring and controlling the quality of child protection work.

2. There is a management system for the appraisal, inspection and management review of cases.

3. Supervision of child protection workers is one part of the management system used to appraise workers' performance and promote their development.

4. Management have begun to help staff build in ways of measuring the outcome of their work.

5. Referrals to the complaints procedure are regularly reviewed for their relevance to child protection work.

6. Client satisfaction of the service is regularly reviewed through inspection, child protection case conferences and client attitude surveys.

STANDARD 22

The SSD has a clearly stated policy detailing the expected content and quality of supervision, as well as addressing its resource implications.

CRITERIA

1. Each worker engaged in child protection work has a named supervisor.

2. Supervisors of child protection workers have a social work qualification, experience in the child care/child protection field and understand the nature of the supervisory role.

3. The line managers of supervisors allocate sufficent time for them to supervise their staff.

4. A contract has been made between the supervisor and child protection worker.

5. Each child protection worker knows who they can contact in their organisation, if the terms of their supervisory contract are not met.

6. Supervision sessions take place on a regular, planned basis, and are recorded.

7. Supervision sessions are set at a level of frequency which reflects the worker's level of experience and competence; they are available at least monthly.

8. The content of supervision sessions covers agency and ACPC policies and procedures as well as the practice, knowledge and skills required to investigate, assess, plan and implement child protection plans. It addresses issues of control, support and guidance in the management of all cases but in particular complex ones.

8 RECORD KEEPING

STANDARD 23

The SSD has a policy on record keeping which states the purpose and format for keeping records. It covers the need to retain records for appropriate periods of time. Appropriate procedures are in place to safeguard information and to ensure timely transfer of relevant records when a child and/or family moves to or from the area.

CRITERIA

1. The SSD has a policy on record keeping for child protection which covers the need to retain records for appropriate periods of time.

2. Procedures are in place which safeguard the information contained in the records.

3. The purpose and the format for keeping records is clear.

4. Relevant records are transferred to another area or local authority, at appropriate times

when a child or family moves.

STANDARD 24

The SSD has a policy on the videotaped recording of interviews, which states the purposes for making the records and how they will be used. It addresses who holds the copyright for videotaped recordings and who, under what circumstances, can have access to the videotapes. Appropriate procedures are in place regarding their storage. There is a policy on how long they will be kept.

CRITERIA

1. The SSD's policy for the making and use of videos takes account of relevant legislation, Government guidance, judgements made in the Courts and recommendations of national enquiries.

2. The SSD has a policy on the videotaped recording of interviews which sets out the purposes for making videotaped recordings and how they are to be used, by whom, under what circumstances.

3. The policy addresses who holds the copyright for videotaped recordings and when the child, those with parental responsibility, other professionals and the Courts can have access to the videotapes.

4. The policy covers the length of time videotapes should be kept.

5. The safe storage of videotapes is covered in the procedures.

6. Procedures set out clearly how consent is to be obtained from the child and family members being interviewed, and how to enable those being interviewed to understand fully the possible implications of a videotape existing.

STANDARD 25

The content of case records is sufficient to give a comprehensive account of the work undertaken. The records are unambiguous, balancing economy with accountability and clearly distinguish fact from opinion. They contain regular summaries helpful to supervision and inspection.

CRITERIA

1. Each record has a front sheet containing relevant information about the child and the family, and professional systems they belong to.

2. The records cover all stages in the child protection process. They give details of referral, investigation, assessment, decisions made at conferences and other significant meetings and the rationale for these, details of the Child Protection plan and its implementation, and conference minutes.

3. The records are accurate, clear and contain all relevant information known to the agency about the child and the family.

4. The records separate out content, opinion and third party information.

5. Records are used during the supervisory process to monitor the worker's involvement with the child, and in carrying out the child protection plan.

B. DIMENSIONS OF AGENCY PERFORMANCE

9. POLICY

STANDARD 26

The SSD has a clearly written, comprehensive child protection policy.

CRITERIA

1. The child protection policy is an integral part of the SSD's child care policy, is consistent with ACPC policy, and is formally endorsed by the Social Services Committee.

2. The policy is based on current statutes, related regulations and guidance.

3. The policy is based on current knowledge, practice developments and research findings about what constitutes a quality child protection service.

6. The policy states the SSD's commitment to the delivery of services which are anti-discriminatory and sensitive to the needs of children and their families.

7. The policy takes account of the views of consumers of the service.

8. The policy is written in a language and style which can be understood by social service professionals, other staff in the SSD, users, carers, and members of the public.

9. The policy states that all children whose names are on the Child Protection Register should have an allocated key worker.

10. The policy is regularly reviewed and revised to take account of new developments in child protection services and of any changes in the legislation, regulations and guidance.

STANDARD 27

The child protection policy is operationalised through written procedures and practice guidance, which are actively promoted within the Department.

CRITERIA

1. Departmental procedures and practice guidance cover all the key aspects of the child protection policy.

2. Users of the services are involved in the development of the practice guidance.

3. The departmental procedures clearly identify the levels of management within the SSD which are responsible for making key decisions about child protection cases.

4. The departmental procedures include a system for the management and monitoring of temporarily unallocated child protection cases.

5. The departmental procedures and practice guidance reflect the need for the SSD to support families, to provide services and to reduce risk to children.

STANDARD 28

The SSD's child protection policy is available to all relevant staff, agencies, users and members of the public.

CRITERIA

1. All SSD staff involved in child protection work have a copy of the child protection policy.

2. All SSD staff have access to a copy of the child protection policy.

3. Copies of the policy are shared with other ACPC members.

4. Copies of the policy are available to users and members of the public and are easily obtained.

10. INTER-AGENCY WORKING: POLICIES AND PROCEDURES

STANDARD 29:

The SSD has a firm commitment to working with other agencies to ensure the planning, resourcing, implementation and review of child protection services.

CRITERIA

1. The SSD ensures that services are planned on the basis of need with other agencies on the ACPC.

2. The SSD, along with other agencies on the ACPC, commits resources to interagency work and initiatives, particularly joint training.

3. The SSD ensures that interagency plans for the provision of services are implemented and that progress is monitored.

4. Services are reviewed, with other agencies, at least annually.

STANDARD 30

The SSD contributes to inter-agency co-operation for the protection of children.

CRITERIA

1. SSD policies and procedures emphasise their lead role in the management of individual cases.

2. The SSD endorses the policy, procedures and joint working of the ACPC.

3. The SSD is committed to joint training with other agencies.

4. The SSD establishes the level of need identified to undertake the assessment, treatment and support of children and families and the level of resources required to meet these needs. This information is brought to the attention of the ACPC members.

STANDARD 31

The SSD is committed to undertaking lead responsibility on the ACPC for specific functions.

CRITERIA

1. The SSD is responsible for the appointment of the Chair, Secretariat, and support services of the ACPC.

2. Where the Chair is appointed from the SSD, she or he should be at least at Assistant Director level and possess knowledge, skills and experience in child protection work, including chairing skills.

3. Where the Chair is appointed from outside the SSD, the vice-chair is appointed from within the SSD.

4. The Director of the SSD ensures that the Department takes the lead in monitoring the implementation of local procedures and the effectiveness of arrangements for the protection of children.

5. The SSD takes responsibility for securing legal advice for the ACPC.

STANDARD 32

The SSD as a constituent member of the ACPC carries out its interagency work within an appropriately constituted and resourced ACPC.

CRITERIA

1. The SSD contributes to and works within the agreed terms of reference which set out the remit of the ACPC.

2. The SSD works within the clearly defined and agreed relationships between the constituent agencies of the ACPC.

3. The SSD endorses the policies, procedures and actions of the ACPC.

4. The SSD is represented by an appointee who has sufficient authority to speak on behalf of the SSD and to make decisions at an agreed level without reference back.

5. The SSD contributes to and agrees the budget the ACPC requires to accomplish its task and support the secretariat.

STANDARD 33

The SSD as part of the ACPC contributes to the establishment of a programme of work which develops and keeps under review local joint working, policies and procedures.

CRITERIA

1. The SSD in conjunction with other constituent agencies helps ensure that the ACPC:

   - establishes, maintains and reviews local interagency guidelines on procedures to be followed in individual cases;

   - produces a local procedural handbook, which is accessible to all members of staff in constituent agencies, independent practitioners in direct contact with children and families and available to the public, for example through local libraries and SSD offices;

   - monitors the implementation of its local procedures;

   - identifies significant issues (both positive and negative) arising from the ACPC's review of cases, and reports from enquiries;

   - commissions and establishes appropriate sub-groups to assist in policy formulation;

   - scrutinises arrangements to provide treatment, expert advice and interagency

- scrutinises progress on work to prevent child abuse and makes recommendations to the responsible agencies;

- scrutinises work related to interagency training and makes recommendations to the responsible agencies;

- conducts reviews required under part 8 of Working Together, 1991;

- publishes an annual report about local child protection matters;

- on a regular basis, receives management information about the level of activity in child abuse work, including details of type and trends.

11. STAFF COMPETENCE AND DEPLOYMENT

STANDARD 34

The SSD has identified the knowledge and skills required for child protection work and deployed a workforce which possesses these.

CRITERIA

1. The SSD has a staff development policy which addresses the need for appropriate training and supervision for individual workers in child protection work.

2. Staff are adequately trained, qualified and experienced to undertake the tasks expected of them.

3. Staff are not asked to perform activities which are inappropriate to their level of competence or position within the departmental hierarchy.

4. Named key workers have a social work qualification and, with an appropriate level of supervision, are competent to undertake the child protection work allocated to them.

STANDARD 35

The SSD has a clear management plan for the training and development of all staff involved in the delivery and administration of child care services.

CRITERIA

1. The staff development plan is derived from the department's child care policy.

2. The training and development of all individual staff members involved in child care services is incorporated into the department's policy on staff development.

3. Training programmes are developed to match the needs of practitioners, supervisors, managers, trainers, administrative and support staff, according to the same departmental policies, procedures and guidance.

4. The SSD has a system for identifying and analysing the developmental and training needs of individual staff, and then providing appropriate training for them.

5. There are specific training programmes which take account of the different needs of all staff engaged in child protection work.

6. Training is offered at different levels of complexity from induction courses to those focusing on highly specialised areas of work.

7. Training reflects contemporary good practice with a wide range of child protection problems, current research findings on child protection and the legislation. The content spans the process from awareness of child protection issues to methods of helping families to change, and it emphasises the development of skills and knowledge.

8. Where appropriate, training programmes are jointly planned with other agencies and are multi-disciplinary in focus and content.

9. The effectiveness of the child protection training programme is routinely evaluated.

10. The training programme is regularly reviewed and updated.

12. OPERATION OF THE CHILD PROTECTION REGISTER

STANDARD 36

In each area covered by the SSD a register is maintained which lists all the children for whom there is a child protection plan.

CRITERIA

1. The child protection register encompasses the following categories of abuse: neglect, physical injury, sexual abuse, emotional abuse.

2. The entry of a child's name on the child protection register only occurs following discussion at a child protection conference, with one exception, that is when a child on another Local Authority's register moves into the area. Such children are registered immediately, pending the first child protection conference in the new area.

3. A child's name is placed on the register because there are current unresolved child protection issues and the child is subject to an interagency child protection plan.

4. The placing of a child's name on the register is not used to obtain resources which might not otherwise be available to the child and their family.

STANDARD 37

There are clear procedures for registration, review, and de-registration of children.

CRITERIA

1. There are procedures for registration, which are clear and uniformly understood by staff of all relevant agencies.

2. There are clear de-registration procedures which are uniformly understood by staff of all relevant agencies.

3. Procedures for registration and de-registration clearly state the criteria to be used when making these decisions.

4. The child protection plan for each child is reviewed at a child protection conference at least every six months.

5. If there is a significant change in the child's circumstances during the six month review period, the child protection plan is reviewed at a child protection conference and updated.

Inspection Background and Method

APPENDIX B

The inspection was conducted using a selection of standards from the set developed by SSI and published in the DH publication "The Standards used by the Social Services Inspectorate: Volume II Childrens' Services". Specifically the practice was examined under the following standards:

- recognition and referral;
- immediate protection and identifying the nature of concern;
- initial investigation and assessment;
- decision making about registration at child protection conferences;
- comprehensive assessment;
- planning;
- management;
- record keeping;
- policy;
- interagency policy and procedures;
- staff competence and deployment;
- operation of the child protection register.

A full exposition of the standards can be found at Appendix A.

Because this was a follow-up inspection the methodology concentrated on an evaluation of the extent to which the recommendations contained in the original report had been addressed and the necessary action taken on them.

Interviews Carried Out, Meetings Attended and Case Files Examined During the Inspection

APPENDIX C

The inspection included an examination of a stratified sample of case files chosen by inspectors in advance of the fieldwork; interviews with the social workers and their first line managers, relevant SSD senior managers, middle managers and trainers, members of other agencies represented on the ACPC and service users.

The case sample was made up of 36 cases which had been worked on by the SSD between 5 May 1998 and 31 September 1998. It comprised cases upon which no action had been taken, cases which had been subject to enquiries under Section 47 of the Children Act but not considered to need initial child protection conference; cases which had been subject to an initial child protection conference but had not been registered and cases which had been registered. A proportion of the cases had been active prior to the sampling date and had continued to be worked with; the remainder were newly referred cases.

We examined the cases in detail prior to beginning the fieldwork. When in Cambridge we interviewed the social workers and their team leaders, and as many of the families involved in the cases which had been subject to enquiries as would agree. We also asked the families to complete questionnaires relating to their experience of the child protection service.

We examined a range of policy and procedural documentation and statistical information. In addition we received completed questionnaires from 31 social workers, 7 line managers and 13 parents.

We interviewed the following:

- the Chair and party spokespersons from the Social Services Committee;
- the Chief Executive;
- the Director of Social Services;
- the Assistant Director Children and Family Services;
- the Assistant Director Quality and Performance Review;
- two Operations Managers;
- 12 team managers;
- 35 social workers;
- the Child Protection and Review Co-ordinator;
- four child protection co-ordinators;
- the central support team;
- the Complaints Officer (both temporary and substantive);
- two child care trainers;
- the Policy and Performance Review Manager;
- the Chair of the ACPC;
- the Staff Officer to the ACPC;
- ten agency representatives of the ACPC;
- the parents of three of the children whose case files we studied.

Training and Experience Received by Staff

APPENDIX D

TRAINING RECEIVED BY LINE MANAGERS

Total Number of Line Managers = 10

Training undertaken by Line Managers	**Internal**	**External**	**Both Internal & External**
Children Act	**9**		**1**
Child Development	**5**	**2**	**2**
Recognition of Types of Abuse	**7**	**1**	**2**
Child Sexual Abuse	**6**		**3**
Investigation in Child Protection	**8**		**2**
Joint Training	**8**		**1**
Assessment in Child Protection	**4**		**3**
Treatment/Continuing work in Child Protection	**4**	**2**	**1**
Management (General)	**7**		**2**
Management (Child Protection)	**3**		**2**
Supervision (General)	**5**		**1**
Supervision (Child Protection)	**7**		**1**

AREAS OF CHILD CARE WORK COVERED

LINE MANAGERS
(TOTAL 10)

Number of years spent in Areas of Child Care work	**Up to 2 yrs**	**3 to 4 yrs**	**5 to 6 yrs**	**7 to 10 yrs**	**>10 yrs**	**None or years not given**
Types of Child Care work:- No of LMs						
Residential Child Care	**2**		**2**			**6**
Day Care	**1**					**9**
Fostering/ Adoption						**10**
Family Centre	**1**					**9**
Fieldwork				**1**	**8**	**1**

TRAINING RECEIVED BY SOCIAL WORKERS

Total Number of Social Workers = 30

Training undertaken by Social Workers	**Internal**	**External**	**Both Internal & External**
Children Act	**21**	**4**	**5**
Child Development	**14**	**8**	**8**
Recognition of Types of Abuse	**21**	**1**	**7**
Child Sexual Abuse	**16**	**1**	**9**
Investigation in Child Protection	**25**	**1**	**2**
Joint Training	**23**	**1**	**1**
Assessment in Child Protection	**21**	**2**	**3**
Treatment /Continuing work in Child Protection	**11**	**3**	**4**

AREAS OF CHILD CARE WORK COVERED SOCIAL WORKERS (TOTAL 31)

Number of years spent in Areas of Child Care work	**Up to 2 yrs**	**3 to 4 yrs**	**5 to 6 yrs**	**7 to 10 yrs**	**>10 yrs**	**None or years not given**
Types of Child Care work:- No of SW's						
Residential Child Care	**6**	**3**		**1**	**1**	**20**
Day Care	**1**		**1**	**1**	**1**	**27**
Fostering/ Adoption	**1**	**1**		**1**		**27**
Family Centre	**1**	**2**				**28**
Fieldwork	**5**	**5**	**4**	**4**	**8**	**5**
Youth Justice	**2**					**29**
Clinical Practice	**3**					**28**
Child Protection	**4**	**5**	**1**	**7**	**4**	**10**
Other	**4**	**2**	**1**	**1**		**23**