Suite of National Safeguarding Reports published 14/5/21 – Summary and Key Points for ADCS

(1) Child Safeguarding Practice Review Panel – Annual Report for 2020

Methodology

Report drawn from Serious Incident Notifications; Rapid Reviews; Local Child Safeguarding Practice Reviews (LCSPR)**;** 30 Serious Case Reviews published in 2020; the Panel's National Reviews; Qualitative analysis of all LCSPRs and 25% sample of Rapid Reviews; Analysis of safeguarding partners yearly reports (undertaken by the What Works Centre Children's Social Care).

Annie Hudson's Key Messages:

"…a period of unprecedented test and challenge…. the still relatively new national architecture for safeguarding… there is much more to do to enhance the impact and effectiveness of local and national learning….Over the next 12 months, the Panel will be looking to strengthen its reach and relationships with all its stakeholders, including safeguarding partnerships and across government." (Key development here to provide a Panel link to partners in each of our ADCS regions, and Panel will share quarterly data and analysis.) Three headline messages:

1. To give a real and strong voice (and influence) to children

2. The urgency of addressing what might be described as stubborn and perennial problems in multi-agency child protection practice e.g. weak information sharing, communication and risk assessment

3. The need to understand and evaluate robustly the impact of learning from rapid reviews as well as local and national practice reviews.

Six key practice themes to make a difference

1. Understanding what the child's daily life is like

2. Working with families where their engagement is reluctant and sporadic

3. Critical thinking and challenge

4. Responding to changing risk and need

5. Sharing information in a timely and appropriate way

6. Organisational leadership and culture for good outcomes.

Other key points in the Panel's analysis

- Quality of Rapid Reviews and LCSPRs is too variable, too often weak on analysis and LSCPRs too often look like old-fashioned SCRs and too often not published
- Covid-19 risk factors most marked in relation to those factors most prevalent in notifications: NAI in children under 1, SUDI and suicide
- Emerging trend: notifications relating to children who had committed suicide where gender identity issues had emerged as a significant factor in seven incidents within the sample
- Disproportionality particularly marked among Black teenagers and among mixed ethnicity children of all age groups. In a number of rapid reviews, the ethnicity of the family does not feature in the characteristics described or analysed.
- 51% child deaths in 2020 were either SUDI or suicide

- National review of **SUDI** in families where the children are considered at risk of harm: development of a 'prevent and protect' practice model has the potential to reduce the risks of SUDI
- Preventing **self-harm and suicide** – Panel's analysis of 98 notifications where the child had committed suicide. The themes included: abuse or neglect from others, bereavement, relationship issues, substance misuse, children missing from home and bullying in an educational setting
- Learning from practice reviews indicates that the recognition of **cumulative neglect** and its impact continues to be a key challenge for practitioners, with incidents of neglect too often treated in isolation
- Responses to incidents of **domestic abuse** were most effective where there was a robust analysis of risks to the victim and support for them; swift action to ensure safety of the children and provide on-going support in recognition of emotional abuse; and purposeful work with the perpetrator, followed up to monitor the extent of sustained engagement and positive outcomes
- From a sample of 89 cases where **children in care** died or suffered serious harm, the analysis focused on 48 incidents where children became looked after as a result of abuse or neglect Key findings were that these were primarily late entrants to care having experienced long-term parental abuse and neglect, with significant trauma, criminal exploitation continued once in care, high incidence of risk-taking behaviours and placement breakdown
- The strategic use of feedback from families is less well developed
- Partnerships are looking to implement more systematic approaches to learning, but too often lack of evidence of impact. The evaluation of the impact of learning (including training) is a key area for development local partnerships. This will be a focus for the Panel in 2021
- Notifications: 38% of areas made 1 or 2; 43% made 3 to 6. Most notifications open to varying local interpretation have related to SUDI, suicide and some criminal harm such as knife wounds – the Panel is considering if further guidance would be helpful
- Just 21% of Rapid Reviews were completed within 15 days – recognition of Covid impact
- 35% of Rapid Reviews lead to a LCSPR. Partnerships are increasingly making more nuanced decisions about whether new learning will result from undertaking an LCSPR. Panel agreed with 69% of decisions. If a rapid review has indicated that there is more learning to be gained, safeguarding partners should move to an LCSPR. There are no other types of review needed or allowed within Working Together (2018).

Looking Ahead

The Panel has agreed a number of priorities which will inform and shape its work programme over the next one to two years:

- Explore how best to make sure that the voice and perspectives of children and families are at the heart of safeguarding reviews and system learning
- Enhance appreciation of the impact of culture, race and ethnicity on safeguarding practice
- Extend ways in which the Panel engages with local and national leaders and policy makers, maximising its influence through timely and effective communications
- Assess our impact so that we better understand the difference we make and how we can enhance our contribution
- Develop, with others, our approach to learning and change, so that learning is effectively embedded.

"We are not minded to commission too many national reviews without evidence that we, and the system as a whole, has the capacity to respond."

(2) Wood Report – Review of New Multi-Agency Safeguarding Arrangements

Context

Covid-19 impact and positive partnership responses; Alan has submitted this report to Care Review; early days of the new arrangements.

Key Issues

Overall the review finds grounds for optimism; resources "under much stress" with reference to the ADCS Safeguarding Pressures 7 report; central government does not demonstrate a joined-up culture.

Focus upon: accountability and judgement of the local partners; lack of joined up approach from inspectorates; variability in respect of engagement of all local partners, specifically of schools; need to build evidence base on impact of independent scrutiny; attention needed specifically on the actions of the named senior leads – CEX, CC and COO; government initiatives from single departments without consideration of multi-agency partnerships; notes lack of guidance for Elected Mayors, Police and Crime Commissioners, council leaders, councillors and chairs of NHS boards.

Survey Results from 117/132 partnerships

- 90% positive about the reforms
- Over half asking for further guidance
- Key challenges: differences in geography and scale between the three partners; resourcing challenges; contextual safeguarding, domestic abuse and mental health.

Leadership: Too much delegation to junior officers (police in particular) who are unable to take strategic decisions; inequitable funding contributions – Police in London particularly highlighted; escalation to resolve issues not always working; senior three leaders typically not meeting together on safeguarding; question of whether partnerships are too operational and insufficiently strategic; question of LA dominating leadership and carrying the support functions for partnerships; anomaly of statutory guidance being offered for LA roles e.g. DCS, but not the others.

Relevant Agencies: The complexity of engaging with several hundred schools requires a detailed network of representation; highlighted issue of unregistered schools and EHE.

Independent Scrutiny: Wide range of approaches evident; not always focussing on the impact for children; not sufficiently focused on the impact of the joint leadership of the three statutory partners. Alan highlighted work of Jenny Pearce (Uni of Beds) and the 'Six Steps Model.'

Inspection: The inspectorates only taking single agency perspectives and therefore partial view; suggestion of the use of JTAI to assure the strength and effectiveness of local area arrangements.

Government: Still characterised by single department approaches; national agenda sitting at junior level of civil servants including the Safeguarding Children Reform Implementation Board; MHCLG should join as a 4th department.

21 Recommendations focused around:

- Central government join up, senior leadership and additional guidance
- Joint inspection arrangements
- Just one recommendation for Local Partnerships to review the level of support, analysis and intelligence in place

(3) What Works for CSC – Analysis of Safeguarding Partners Annual Reports 19/20

Context

A total of 68 reports were submitted, this report draws from a deep dive analysis sample of 19. Focus on this year of transition plus Covid-19 impact.

Headlines

Only 11/68 reports evidenced Working Together requirements in full:

- The **best reports** made use of a range of evidence sources (data, inspection, multi-agency audit, workforce feedback, and the views of children and families) to identify priorities and evaluate their impact. A critical overview of the effectiveness of local arrangements was provided, including details of those aspects where limited or no progress had been made. Reports outlined how the learning from reviews informed improvements in terms of strategy, procedures, models of practice and workforce development. As well as describing new partnership governance arrangements, there was evidence of steps to look at their impact, particularly through leadership forums focusing on 'stubborn challenges', formal sub-regional working, and independent scrutiny.
- **Weaker reports** were descriptive rather than evaluative, with a focus on actions completed in relation to partnership priorities. A number of the required elements in the report were not covered: most frequently these concerned early help, children in care, and care leavers. Information about multi-agency training and levels of participation was provided, but with limited or no analysis of impact. Similarly, evidence of learning from multi-agency audits and case reviews was outlined, and methods to disseminate learning highlighted, but with limited or no evidence of the impact of that learning. In some cases, independent scrutiny arrangements had only recently been developed, with limited or no independent scrutiny of the evidence cited in the report.
- Researchers found considerable variation in the length of report and the detail provided; the sample in the 'deep dive' audit ranged from 11 pages to 124, with most in the range 30-40 pages. The length of the report was not an indicator of quality.
- Analysis suggests the need for yearly reports to have a sharper focus on impact, evidence, assurance and learning.

Suggestions for Local Partnerships to review the following key points:

1. *Are your Rapid Reviews and LSCPRs sufficiently analytical and focused upon usable learning? Local Leads to read the relevant sections of the Panel's Annual Report.*
2. *Do your Rapid Reviews and LSCPRs always consider ethnicity and culture in respect of the family and how this was considered by partner agencies?*
3. *Do you initiate LSCPRs on the basis of evidence that this will generate local system learning or just because a threshold is met in relation to a single child?*
4. *How are you gathering feedback from families in receipt of safeguarding interventions?*
5. *How are the most senior leads for each statutory partner engaged in the children's safeguarding agenda both individually and together?*
6. *Will your annual report for 2020/21 cover the requirements of Working Together and reflect an analytical focus on impact? Local annual report authors to read the WW4CSC report.*

Summary written by James Thomas, DCS Tower Hamlets, ADCS lead on Safeguarding Reform.