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CHILDREN AND ADULTS OVERVIEW AND SCRUTINY COMMITTEE

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MEDWAY SAFEGUARDING CHILDREN BOARD ANNUAL REPORT 2009/2010 AND BUSINESS PLAN 2010/11

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Summary

This report updates the Committee on the work of the Medway Safeguarding Children Board (MSCB) in 2009/10 and the development of its business plan for 2010 - 13. The report and an accompanying introduction to be made to the Committee by the Independent Chair of MSCB will enable Members to scrutinise the performance and plans of the Board.

1. Budget and Policy Framework

1.1 The Medway Safeguarding Children Board (MSCB) is set up under the Children Act 2004 and has the following main objectives:

- To **coordinate** what is done by each agency represented on the Board for the purposes of safeguarding and promoting the welfare of children in Medway
- To **ensure the effectiveness** of what is done by those agencies for that purpose

1.2 The MSCB has a pooled budget made up from financial contributions from its constituent statutory partners

2. Background

2.1 As part of the Board's governance arrangements, the Independent Chair of MSCB presents progress reports to the committee twice a year to enable Members to scrutinise performance and to hold the Chairman to account for the work of the Board.

2.2 The importance of robust and regular overview of the MSCB's work by elected Members is consistent with best practice identified in the statutory guidance Working Together 2010.

2.3 MSCB is not responsible for direct commissioning or delivery of safeguarding services. Its role is to ensure the effectiveness and coordination of the work of local partners singly and collectively to safeguard and promote the welfare of children. It does this through developing policies and procedures, commissioning multi agency safeguarding training and through challenge, support and quality assurance activities.

2.4 In previous years, the MSCB business plan has been focussed mainly on processes and activities and had not sufficiently reflected the impact of its work on improving outcomes for children. This year, the MSCB has adopted an approach based upon a model of outcome-based accountability in order to evaluate the effectiveness of both the Board and its constituent partners. The review of activity therefore asks three questions:

- What did we do?
- How well did we do it?
- Did we make a difference?

2.5 Board partners have also been asked to consider the same three questions when reviewing their own safeguarding activity during the previous year and then identify their future plans in terms of the outcomes they wish to achieve to demonstrate that they are making a difference to children and their families.

3 Key achievements in 2009/10

The annual report 2009-10 gives full detail and is available at www.mscb.org.uk. A summary of key achievements is listed below.

3.1 Key Objective 1: Improving and promoting best safeguarding practice

Safer Employment and professional standards.
Desired outcome: Minimising the risk to children from those who work with them

3.1.1 During 2009, the MSCB continued to deliver its programme of safer recruitment 'train the trainer' events to ensure that partner agencies had a minimum of one member of their staff group able to deliver training to staff with responsibility for recruitment. Audits undertaken in September 2009 demonstrated that all schools in all sectors in Medway and all statutory partners in the MSCB had achieved this.

3.1.2 Biannual reports from the Local Authority Designated Officer (LADO) indicate that partner agencies are referring allegations against staff appropriately and in a timely fashion. Investigations are also being completed within timeframe.

Child death review processes

Desired outcome: MSCB is compliant with statutory requirements and multi-agency collaboration reduces preventable child deaths in Medway

3.1.3 Under the Children Act 2004, LSCBs must establish Child Death Overview Panels (CDOPs) which will review the deaths of <u>all</u> Medway children – that is, children normally resident in Medway, regardless of where they died. The Medway CDOP is well established and is chaired by the Director of Public Health.

3.1.4 The child death notification process continues to work effectively – notifications are made within good time and with the appropriate information. This means that families who have suffered a bereavement have received a swift, consistent and coordinated response from the agencies involved. National statistics published recently suggests that Medway is broadly in line with other regions in terms of the numbers, preventability of and response to child deaths. In 2010, the CDOP will introduce agreed performance targets which will aim to measure the effectiveness of the Rapid Response and of the Panel itself.

3.1.5 Between April 2009 and March 2010, 23 Medway children died – 17 of them were expected deaths and 6 were unexpected. One unexpected death was reviewed statutorily as a serious case review under Chapter 8 of Working Together during the period, whilst a second is currently being reviewed. All but one of the deaths reviewed by the Panel during the year has been judged to have been unpreventable (as per criteria set out by DCSF). With the one case that was deemed preventable the panel identified that there were potential modifiable factors that could lead to the prevention of future deaths. This was in relation to a sudden infant death (SIDS), which, in itself, was unexpected, unexplained and unpreventable. There were however some concerns which arose as part of the Rapid Response processes immediately following the child's death, that were indicative of high risk factors associated with SIDS. This case is currently being reviewed as a serious case review.

3.1.6 It is difficult to establish what difference the CDOP has made to improve outcomes for children, as the numbers of child deaths that it reviews are too small to facilitate the identification of trends and patterns. However, the information gathered does feed in to regional and national data and from this, more reliable conclusions can be drawn. Annual CDOP data will be reported by the Department of Education in due course.

Child Protection Process
Desired Outcome: processes are fit for purpose and promoting positive outcomes for vulnerable children

3.1.7 In early 2009, MSCB commissioned the Council, Kent Police and NHS Medway to conduct self audits against the Laming recommendations. During the latter part of 2009, the MSCB Quality Assurance & Case Review (QACR) Subgroup also undertook an audit of partner's compliance with s11 of the Children Act 2004.

3.1.8 The returns from both audits highlighted similar strengths and good practice – all partners have dedicated and named safeguarding leads and make reference in their corporate plans to their safeguarding responsibilities; all partners have safeguarding policies and procedures in place, including those for safer recruitment, vetting and allegations against staff and clear lines of accountability in relation to the safeguarding of children. There were also similar areas for development which are being addressed through the 2010/11 business plan. These include:

- The consistent implementation and use of the Common Assessment Framework[1] (CAF) by local agencies;
- The need for improved information sharing, management oversight and case supervision;
- Consistent application and clarity of threshold criteria for referrals to Children's Care across all agencies;
- Improved and systematic engagement and involvement of children, young people and their families in service planning and development;
- Improved attendance at Child Protection Conferences;
- Improved multi-agency safeguarding training which reflects workforce needs;
- Consistent implementation of safer recruitment methods.

3.1.9 Recommendations to improve practice that were identified by the Ingson Review in early 2009 were also implemented during the year and overseen by the MSCB through the 2009/10 Business Plan.

3.1.10 Significant progress has been made against the Ingson report's recommendations in relation to improvements in the process and administration of and multi-agency preparation for Child Protection Conferences and improvements in the numbers of social workers' reports available to Child Protection Conferences that have been shared with parents/carers prior to the conference.

3.1.11 Improvements in the ways that Child Protection Conferences are managed means that appropriate information is shared by professionals who are most closely involved with families and that

[1] The Committee received a report and presentation on CAF at its meeting on 27 May 2010

3.1.12 quality decisions can be reached by the Child Protection Conference and its constituent members, as well as senior officers from other statutory partners.

3.1.13 Improvements in the attendance of primary healthcare practitioners, including health visitors and midwives, at pre-birth Child Protection strategy meetings and Child Protection Conferences (CPCs) have meant that key professionals have been able to share information and expertise, particularly at an early stage in planning for children both ante- and post-natally. The reflection of children's views, wishes and feelings are now a requirement of every social work report to Child Protection Conferences and this is monitored by the Quality Assurance reports provided by the MSCB Manager on a month on month basis and reported to the Director for Children's Services.

3.1.14 The Policy and Procedure subgroup reviewed the contents of the Kent and Medway Safeguarding Children Procedures 2007. A new edition will be published in late 2010 to reflect new requirements in Working Together 2010. This will be a joint venture between the LSCBs in both Kent and Medway and will ensure consistency in policy and practice across the area.

Serious Case Reviews (SCRs) and Lessons Learned Reviews (LLRs)

Desired Outcome: SCR and LLR recommendations are effectively implemented to improve child safety, with reviews completed within time and judged to be of good quality.

3.1.15 LSCBs undertake serious case reviews when a child dies, or suffers serious harm and abuse or neglect are known or suspected to be a factor in the death or serious injury. This is to ascertain whether there are any lessons to be learned about the ways in which organisations work together to safeguard and promote the welfare of children.

3.1.16 The Board completed its first SCR in July 2009 and this was judged by Ofsted to be "good". In March and April 2010, the MSCB held "lessons learned" sessions for Board members, the Panel and Individual Management Review (IMR) authors to discuss what worked well and how the process may be improved in the future. These include better preparing agencies for the requirements of the IMR task - supporting IMR authors to understand the Ofsted standards against which their reports will be judged, supporting line managers to understand the practical and emotional demands that staff writing reports may face and the support they may require and ensuring action plans are clear, outcomes focussed and accountable. Recommendations from these meetings will be carried forward into the new practice guidance in order that we learn from our experience.

3.1.17 Key improvements brought about by the action plans that are created by the SCR process are as follows:

- Waiting lists for children needing a service from Child and Adolescent Mental Health Services (CAMHS) have been shortened. Children are seen by the Child and Adolescent Support Team (CAST) within 10 days of a referral being made.

- In late 2009, NHS Medway appointed a Named GP for Child Protection – a post that was recommended in a number of previous lessons learned reviews in order to implement best practice and help ensure GPs positive contributions to Child Protection Processes.

3.1.18 The MSCB started another SCR in March 2010 following the Sudden Infant Death of a young baby whose home environment gave rise to professional concern following the statutory "Rapid Response" process that takes place under Child Death Review requirements. The Board has commissioned an independent chair and overview author and aims to complete this review in December 2010.

Multi-agency training and workforce development
Desired outcome: the children's workforce is knowledgeable and provides high quality services and practice across all sectors

3.1.19 In the period 2009/10, 617 staff from local agencies attended a multi-agency training course delivered by the MSCB on subjects such as basic and advanced Child Protection issues and responses, domestic abuse, sex offending behaviour, neglect and communicating and engaging with children. This compares with 375 staff attending such a course during the previous 12 month period and illustrates how efforts to raise the profile of the Board and its multi-agency training programme have increased demand and confidence in the MSCB training offer.

3.2 Key Objective 2: Quality Assurance and Scrutiny

Monitoring effectiveness of safeguarding policy and practice
Desired Outcome: MSCB drives an improvement in practice which leads to improved safety for Medway's most vulnerable children and young people

3.2.1 The Board has, during the year, received reports and updates from both the Child and Family Court Advisory and Support Service (CAFCASS) and Her Majesty's Youth Offending Institution (HMYOI) Cookham Wood following their inadequate inspection judgements given last year. This has allowed the Board to scrutinise improvement plans and assure itself that appropriate action is being taken, whilst providing guidance and support about how outcomes may be achieved. Subsequent inspections of both agencies have noticed significant improvements.

Safe people and Safe Places
Desired outcomes: Children in Medway are resilient, have positive self esteem and know what to do if they feel unsafe

3.2.2 The Board has promoted its e-safety objective throughout the year and delivered two workshops to 25 parents and staff at schools and also 45 staff based at Medway Council's HQ, Gun Wharf during September 2009, in order to target parents employed and based at the Council offices. This supports the work of Medway Council's e-safety officer who has provided safer internet workshops parents at approximately 10 local schools as well as to children who are looked after and their foster carers who have received laptops and internet access as part of the Home Access Initiative. The Board has an e-safety officer, in line with national best practice recommendations and, it has become apparent, that the MSCB's e-safety strategy is ahead of some of its regional peers in its implementation. The MSCB publication, "E-safety: Helping your children use the internet safely" has been in such high demand, it will be refreshed and republished in 2010. Parents, carers and children and young people have all reported finding the booklets and workshops helpful.

3.2.3 There are two specific examples of how this work by the MSCB has made a difference. Firstly, the mother of a teenage child with some learning difficulties who was demonstrating highly sexualised behaviour discovered, after she attended an e-safety workshop, that her child was being groomed online by someone using a chatroom and began to monitor her child's usage of the internet.

3.2.4 A second child who was looked after by the local authority was found by his carers to be putting himself at risk by putting personal information on an open profile on Facebook, which allowed him to be traced by his father, a violent perpetrator of domestic abuse. The child's carers had also attended an e-safety workshop.

Governance and QA
Desired outcomes: the MSCB is accountable, representative and has a positive impact in promoting outcomes for children and young people

3.2.5 In December 2009, the Board appointed a second Independent Chairman, following the end of the previous chairman's three-year tenure. The MSCB worked closely with the Kent Safeguarding Children Board (KSCB) to secure a joint appointment for both Boards to foster and support continuity in practice and policy across the area and maintain appropriate accountability.

3.2.6 In line with requirements of Working Together, the MSCB has secured membership of the Lead Member and Children's Services Portfolio Holder and will look to recruit lay members during 2010/11. The MSCB Chairman is a member of the Children's Trust Board and meets regularly with both the Director of Children's Services, to whom he is directly accountable, and the Lead Member.

3.3 Key Objective 3: Local Safeguarding Priorities

Domestic abuse and violence
Desired outcomes: Children and young people are protected from harm

3.3.1 The MSCB remains committed to its objectives relating to the impact of domestic abuse and the needs of other vulnerable children. A programme to promote awareness of domestic abuse is currently being rolled out through education representatives on the Board supported by training that has been delivered throughout the year to staff across all agencies via the Kent and Medway Domestic Violence Strategy Group and the Board's own training programme. The Board has acknowledged that it has not made as much progress against this objective and has made domestic abuse its key objective focus in 2010/11

Neglect
Desired Outcomes: Children and young people are protected from harm

3.3.2 The MSCB is currently involved in regional research and practice development projects with Government Office South East (GOSE) in relation to the neglect of children. At the time of writing, the Government announced plans to disband the Government Office network and it is unclear what will be happening with these projects. We are awaiting guidance from GOSE. In Medway, neglect accounts for more than 60% of children being subject to Child Protection plans. This is in line with findings across the region as well as nationally and is cited in recent research as being a primary cause of child deaths in the UK. This work will be completed in 2010.

3.3.3 The Board commissioned bespoke multi-agency training on neglect, intervention and preventative practice in September 2009. The Board aims to run this training twice a year in order to raise awareness and improve practice to prevent the longer-term effects upon children's welfare and their ability to achieve positive outcomes. Twenty five practitioners, managers and strategic personnel from all agencies attended this training, which was very positively evaluated. The training materials will be used to create practitioner guide during the next period.

4. MSCB Strategic Aims and Objectives for 2010/13

4.1 The MSCB and its constituent partners have agreed the following strategic objectives for the next three years. These are underpinned by specific objectives, which can be found within the appended business plan.

1. To ensure the effectiveness of the work of local partners to safeguard and promote the welfare of children

2. To ensure the co-ordination of local work to safeguard and promote the welfare of children.

3. To promote continuous learning and development

4 To promote the well-being of vulnerable groups of children

4.2 One of the key areas the Board will be focusing on is the monitoring of how effective services and arrangements are in Medway for the safeguarding of children. A comprehensive quality assurance framework will be developed, focusing on the outcomes being achieved for children and parents, and the experience of parents and children of these services. The aim is that the framework can be used by individual partner agencies, and by the Board to maintain a strategic overview of quality.

4.3 In parallel to this, the Board will be gathering and analysing quantitative and qualitative data from all partners to begin to build a clear picture of safeguarding need in Medway to inform the Children's Trust in it's service commissioning and delivery.

4.4 The Board has identified domestic abuse as its focus in the next year and has set up a task group to establish clear referral thresholds and processes for referral and information sharing between key agencies and to define clear protocols about what each agency will do with such referrals. Domestic abuse was a primary concern for 40% of children subject to Child Protection plans in the period 2009/10 and was a feature in a much larger percentage of cases.

4.5 In the 2010/11 Business Plan, the Board will be working towards the development of a Learning and Development Strategy to underpin the development of the Children's Workforce in conjunction with work being undertaken by the Children's Trust. This will have clear standards, and clear learning and competence outcomes for staff working in MSCB partner agencies and within contracted services.

4.6 The Board is currently working with partners to develop ways in which it can better evaluate the impact that such training has upon improving practice and consequently improving outcomes for children. The Training subgroup are taking this forward and members are embarking upon a programme of telephone interviewing delegates and their managers to evaluate the changes that attendance at such training events has brought to practice and staff confidence.

5. Risk Management

5.1 Effectively managing risk is a key component of safeguarding children. It is the role of the MSCB to scrutinise the effectiveness of agencies in managing these risks to keep children safe.

5.2 A partnership body like MSCB must ensure that it adds value. The adoption of the outcomes based framework on which the 2010/11 business plan is based, seeks to be clearer on the role and impact of the board.

5.3 The biggest risk to the long term operation of MSCB is the reductions in public spending and so contributions from partner agencies. The Board is seeking to mitigate this risk through a clear business plan, which will identify where limited board funds will be used, and where agencies' mainstream budgets will contribute to board activities.

6. Implications for looked after children

6.1 Looked after children are amongst the most vulnerable nationally and in Medway. The MSCB continues to give priority to improving multi agency collaboration to improve the outcomes for looked after children. In particular it scrutinises and seeks to improve multi agency performance in reducing the number of looked after children in a safe and sustainable way. For those children for whom care is the best and safest option, the Board will continue to scrutinise performance to ensure placements are appropriate and stable and that there are good transitions on leaving care.

7. Financial and legal implications

7.1 MSCB is a statutory body funded through government grant and by contributions from local agencies. There are no legal or financial implications for the Council arising from this report.

8. Recommendations

8.1 It is recommended that the Committee scrutinise the annual report and MSCB Business Plan and make any recommendations to the Board for issues to be addressed.

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Background papers

MSCB Annual Review of 2009/10
MSCB Business Plan 2010/11