

# CSN POLICY BRIEFING

## In the child's time: professional responses to neglect – Ofsted survey

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### Summary

The recent report from Ofsted, [In the child's time: professional responses to neglect](#), explores the effectiveness of arrangements to safeguard children who experience neglect. It adopts a particular focus on children aged 10 years and under. The report draws on evidence from 124 cases and from the views of parents, carers and professionals from the local authority and partner agencies.

This briefing will be of interest to those in elected member and officers with responsibility for developing and shaping policy on children's safeguarding.

### Overview


Drawing upon research from a number of different local authority children's services, the report begins by exploring referrals of concern regarding potentially neglected children. It then moves on to look at assessment, interventions and monitoring and reviewing the assessment of cases. In particular the authors look at child in need and child protection plans, measuring change and challenge in instances where there is a lack of progress. The latter half of the report looks at the timeliness of responses, how the workforce is supported through challenges and in training and development, how local authorities do (or do not) learn from serious case reviews and finally their strategic understanding of, and responses to, neglect of children. Overall, it concludes that the quality of professional practice in cases of neglect is too variable, both between and within local authorities and by partner agencies. A number of conclusions are put forward and these are directed at the government, Local Children's Safeguarding Boards and local authorities.

### Briefing in full

The findings from Ofsted's thematic inspection present a mixed picture of the quality of professional responses to neglect. Throughout the report, there are examples of good practice and in some local authorities professionals are employing a range of methods and approaches to working with neglect that are delivering positive outcomes. The quality of professional practice, however, was overall found to vary significantly with the result that a life of neglect is a lengthy reality for some children.

Drift and delay characterised one third of the cases looked at during the research, resulting in failure to protect children from continued neglect and poor planning in respect of their needs and future care. Immediate risk of harm did not face any of the children involved in this research at the time that it was carried out.

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It was found that local authorities are employing a variety of assessment methods to work with families where children are neglected. For some of these, there is a clear evidence base that is highly valued by professionals and enables direct work with families to support strong assessments. Good examples were also found of professionals using a range of indicators to track and monitor the impact of interventions and to measure the progress of children subject to child protection plans. Such methods were found not, however, to be used in all authorities resulting in varied and patchy quality of assessments of neglect cases overall. Almost half of assessments seen either did not take sufficient account of the family history or did not sufficiently convey or consider the impact of neglect on the child. The report concludes that the use of good practice as a tool for learning and driving improvement is therefore critical to increasing the quality of assessments, planning and the management of risk for children who are neglected.

The inspection found that professionals were significantly challenged by parental engagement in child in need and child protection work. The parents of at risk children are likely to have multiple and complex needs and demand significant time and attention from social work professionals. Parental disengagement in those cases where children were not making positive progress was found to be a common feature. However, only a small number of multi-agency groups that were involved in child protection planning had tangible strategies for non-compliance.

The inspection found that whilst most professionals were in receipt of some training focussed upon recognising and dealing with the neglect of a child, there was little effective evaluation of its impact, and on this inspection, in many cases seen, there were no demonstrable outcomes as a result of this. Whilst there is a wealth of research about neglect, practitioners were found to have very little time to access and digest this knowledge and there was minimal evidence of the application of specific research to practice.

Tracking and knowledge management were found by Ofsted to be of particular concern; the local areas visited had difficulty in identifying the prevalence of children in receipt of services for neglect. Local authorities could identify the number of children subject to child protection plans in the category of neglect, but this knowledge is insufficient to provide an accurate estimation of the extent of neglect in a local authority area. Indeed, there will be children who are not yet in receipt of a statutory child protection service but who are receiving earlier help and those whose need or protection plans address other more obvious concerns, such as physical abuse who may also be suffering from neglect. Worryingly, Local Safeguarding Children Boards (LSCBs) did not always understand fully the local prevalence of neglect, making it significantly more challenging to evaluate the effectiveness of multi-agency plans to prioritise and respond to neglect.

Whilst the inspection found much to cause concern, it did find that some local authorities can and are making a positive difference to the lives of many children living in situations of neglect. Unsurprisingly, those local authorities providing the strongest evidence of impactful action to tackle neglect were more likely to have a neglect strategy and/or a systematic improvement programme addressing policy, thresholds for action and professional practice at the front line.

## Key findings

- The quality of professional practice in cases of neglect overall was found to be too variable, although in some of the cases examined at this inspection, children were making progress.

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- Nearly half of assessments in the cases seen either did not take sufficient account of the family history, or did not adequately convey or consider the impact of neglect on the child. Some assessments focused almost exclusively on the parents' needs rather than analysing the impact of adult behaviours on children. In a small number of cases this delayed the action local agencies took to protect children from suffering further harm.
- While the quality of written plans was found to be too variable, there was evidence of some very good support for children that was meeting the short-term needs of the family. However, there was very little evidence of longer-term support being provided to enable sustained change in the care given to the children.
- Some authorities are using effective methods to map and measure the impact of neglect on children over time and to evaluate the effectiveness of interventions. This results in timely and improved decision-making in some cases. However, not all local authorities have such systems in place to support social workers in monitoring the impact of neglect on children and the effectiveness of their interventions.
- Non-compliance and disguised compliance by parents were common features in cases reviewed. Although some multi-agency groups adopted clear strategies to manage such behaviour, this was not evident in all cases. Where parents were not engaging with plans, and outcomes for children were not improving, professionals did not consistently challenge parents.
- Drift was identified at some stage in the child's journey in a third of all long-term cases examined, delaying appropriate action to meet the needs of children and to protect them from further harm. Drift was caused by a range of factors, including inadequate assessments, poor planning, parents failing to engage and in a small number of cases, lack of understanding by professionals of the cumulative impact of neglect on children's health and development. Drift and delay have serious consequences for children, resulting in them continuing to be exposed to neglect.
- Front-line social workers and managers have access to research findings in relation to neglect, although the extent to which this is incorporated into practice varies. It is by exception that front-line social workers use specific research to support their work. The impact of training on professional practice with regard to neglect is neither systematically evident nor routinely evaluated.
- Routine performance monitoring and reporting arrangements to LSCBs infrequently profile neglect. Therefore most boards do not receive or collect neglect data except in respect of the number of child protection plans where the category is recorded as neglect. Most boards were not able to provide robust evidence of their evaluation and challenge about the effectiveness of multi-agency working to tackle neglect.
- Those local authorities providing the strongest evidence of the most comprehensive action to tackle neglect were more likely to have a neglect strategy and/or a systematic improvement programme across policy and practice, involving the development of specific approaches to neglect.
- The challenge for local authorities and their partners is to ensure that best practice in cases of neglect is shared in order to drive improvement.

## Recommendations

The report puts forward a series of recommendations for government, Local Safeguarding Children's Boards (LSCBs) and local authorities.

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## The government should:

- Review the social work reform programme and ensure that training, both before and after qualification, includes mandatory material on neglect, focusing on its identification and assessment, as well as comprehensive training on child development, attachment theory and child observation
- Require (through revised regulations) that all LSCBs develop a multi-agency strategy to increase their local understanding of the prevalence of neglect and to improve the identification of, and responses to neglect.

## LSCBs should:

- Have access to and regularly examine data and quality assurance information to enable them to monitor the quality of practice in relation to neglect across early help, child in need and child protection interventions
- Ensure that all agencies, including adult mental health services; drug and alcohol services; police and social work services working with families where there is domestic abuse; and services for adults with learning difficulties, work effectively together to assess and agree plans for children who experience neglect
- Ensure that practitioners and their managers have access to high-quality specialist training on the recognition and management of parental non-compliance and disguised compliance
- Ensure that the training provided for front-line practitioners and managers enables access to contemporary research and best practice in working with neglect
- Ensure that all staff are aware of their duty to escalate concerns when they consider that a child is not appropriately protected and/or is suffering from neglect, and that all agencies have appropriate escalation policies and procedures, including a procedure for challenging the decisions of children's social care services where cases are not accepted for assessment or child protection investigation.

## Local authorities should:

- Ensure that there is robust management oversight of neglect cases, so that drift and delay are identified and there is intervention to protect children where the risk of harm or actual harm, remains or intensifies.
- Prioritise the training and development of front-line practitioners, focusing on the skills needed to engage in direct work with families and the development of good assessments that describe what life at home is like for children.
- Support social workers and managers in the use of models and methods of assessment that enable them to effectively describe and analyse all risk factors in cases of neglect and then take decisive action where this is required
- Prioritise the development and use of plans to support and protect children suffering from neglect, ensure that those plans set out clearly, with timescales, what needs to change and the consequences of no or limited change; plans should be subject to routine management oversight given the complexity of work with neglected children.
- Ensure that social workers have specialist training and supervision to enable them to exercise professional authority and challenge parents who fail to engage with services, particularly when their children are subject to child protection plans; this process should be subject to robust, regular management oversight and practice audit

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- Ensure that there is clarity about the threshold for care proceedings to be initiated in cases of neglect, and that the threshold is understood, consistently applied and monitored by local authority social care staff, senior managers and their legal advisers
- Oversee the written evidence presented to courts so that it is clear, concise and explicitly describes the cumulative impact of neglect on the daily life of the child.

## Conclusion

The report concludes that urgent and decisive action is needed to address the issues highlighted within it and to drive improvements in practice. It rightly points out that the challenge for local authorities and partner agencies is to learn lessons from those cases where professional responses to neglect are timely and effective, thereby providing families with the help they need. Social work professionals in particular must improve the quality of their engagement with, and assessment of families where children are neglected. The cumulative and pervasive impact of neglect on the development of children and their life chances has to be properly addressed if they are to be able to contribute to, and benefit from society as adults and future parents.

## Comment

The publication of this report coincides with the launch of Action for Children's report '[Child Neglect: the scandal that never breaks](#)'. This is germane and signals that the ongoing challenges facing child safeguarding in the UK are not being resolved – or if they are, resolutions are patchy at best. Indeed, in their report, Action for Children found that 73% of children said they knew another child suffering from neglect. And so it is a fair question – if other children can spot the signs, how come those with a duty of care continue to miss them? Ofsted's report provides a series of clear reasons why. As many as 1.5 million children - one in 10 of the UK's child population – is thought to suffer some form of neglect at present. In light of both of these reports, the assertion by Action for Children that there is no clear strategy to deal with neglect in government is deeply concerning and, by extension, one would hope that the government will listen to the recommendations directed at it through this report.

Worryingly, it is not the first time that the areas of concern that Ofsted highlight have been raised. High quality training for social work professionals, evidence based practice and strong management systems to assess, track and monitor the outcomes for children suffering from neglect are all things that were found to be absent in the serious case reviews with which the public are familiar. With activity currently underway which could see children's safeguarding functions removed entirely from Birmingham and Doncaster councils because of serious failings, one wonders whether there isn't a wider systemic question to be asked about the way the UK protects at risk children from harm and neglect.

With council budgets already reduced by approximately 25% for many local authorities and with further cuts still to come, the financial pressure facing children's services will not be reducing any time soon, not least since referral rates continue to rise placing additional pressure upon already overstretched professionals. More widely, the impact of the recession upon child poverty rates has been [significant](#) with many predicting by 2020, that the number of children living in poverty will be up to 3.4 million. Since poverty and neglect are often associated, this is likely to impact further on local authorities and their ability to identify and deal with neglect.

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The encouraging elements of the report are those that highlight the pockets of excellent practice that were found during this exercise. If the government, local authorities and LSCBs could find a way to distil the learning from such examples and embed it in social work across the country, then the road to high quality services across the board would be paved and improvements would be seen. However, just in the way that the quality of local authorities themselves are patchy, so too are the children's services housed within them, creating a lottery for children and families in need with regards the quality of support they can hope to receive when they need it most. Clearly, this is far from acceptable. The recommendations in this report need to be taken seriously.

## External Links

[In the Child's Time: professional responses to neglect](#), Ofsted, March 2014

[Ofsted: Extent of child neglect 'not understood'](#), BBC, March 2014

## Related briefings

[Provision of children's services in Birmingham and Doncaster, and implications for the future](#), (April 2014)

[Making the education of social workers consistently effective – DfE report](#), (February 2014)

[Ofsted inspection of children in need, looked after children, care leavers and LSCBs](#), (November 2013)

[Ofsted Framework for inspection of services for children in need of help and protection](#), (October 2013)

[Review of the Local Safeguarding Children Board – Ofsted Consultation](#), (October 2013)

[Ofsted Social Care Annual Report 2012-13](#), (October 2013)

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