CSPR 2- so many threads related to hearing children !

Summary recommendations- Chris Freestone.

CSPR 2 …..

The report is built upon the experiences of 108 children and young adults with learning disabilities and complex needs and events occurring between between 1st January 2018 and March 21st 2021.

It builds upon the findings of the phase 1 report which highlighted a broad range of safeguarding issues , risks and abuses which occurred

CSPR 2……..

- This wide-ranging report highlights significant factors which contributed to the culture which developed, and which led to children experiencing:
- significant neglect, abuse and harm
- not having local support and services options to meet their needs
- having their individual cultural needs and dignity violated
- failure by and of the multiple systems and safeguards that should have been in place to protect them

CSPR 2…….

This second report sets out a vision for a secure system for the support for education , health and care of children with disabilities and complex needs.

A key thread throughout is the child’s voice……

CSPR 2…….

1. Promoting the voices and rights of children with learning disabilities and complex health needs who require specialist support
2. Effective strategic commissioning for sufficiency of provision
3. Improving the quality of provision in the community, in schools and in residential settings
4. Strengthening quality assurance and regulation

It is noteworthy that some of the recommendations, mirror / build upon/refer to those in the final report of the Independent Care Review and the work and reporting of Independent Inquiry into Child Sexual Abuse

Practice- are you happy that 1, in particular is robustly in place and evidenced in your service?

CSPR 2……

The report also notes the way in which the cultural backgrounds of children in the care of the Hesley Group in these homes , were ignored and their dignity and rights violated.

e.g.

- black female children had their hair shaved short when they were placed in the homes.
- children's cultural needs were marginalised
- children of differing cultures experienced unacceptable and degrading practices
- human rights were violated

PRACTICE- are you ensuring that the cultural needs of children are fully met ? Do your observations reflect appropriate skills ? Does your workforce development plan reflect appropriate training? are you listening to the views and wishes of children and their families ? Do your team respect the cultures and needs of the children ? Are they aware of the impact of culture on an individual's well-being ?

CSPR 2-The child's voice and their families

- Hearing the voices of children and acting upon them- CRUCIAL. Practice- is this in place? Can you evidence this ? Is it worth carrying out a point in time review of practice and developing as required ?
- Developing and USING individual communication methods-Practice- in place ? Evidence ? Training ? Links to registration and workforce development plan ?
- Children being key partners in decisions about them. Practice- is this happening ? If not, why not and what needs to be changed ?
- A child's right to family life… being placed a long way from home.
- Keeping in touch with home – CRUCIAL. Practice- evidence this is happening ? Communication with families and carers ?

CSPR 2- leadership and the safeguarding culture

"Leadership is key: levels of staff qualification, the induction programmes for new staff and the quality of ongoing training, supervision and support are important, but staff skills and children's experiences are only fully realised in a culture which embraces the value of education and care together in a holistic child-centred environment."(Yvette Stanley 2022)

Practice – can you describe your culture ? Can the team ? Do children inform and shape that culture ? Do you test it regularly ? How would you know when a culture was starting to / had become closed ?

CSPR 2- Deprivation of Liberty..

"We consider that there is an urgent training requirement to ensure that practitioners understand the requirements for legally compliant practice in relation to DOLS. Local authorities, health services and residential settings should review their current systems, procedures and practice to determine their readiness for meeting the requirements under this framework (see supplementary recommendation 1)"

Practice …in terms of practice are you absolutely clear about Dols and the law/ children ? Are your team ?

CSPR 2……. External oversight

- Criticism of all elements with a view to national recommendations for all external partners including :
- Advocacy
- LAs and their commissioning models
- SEND models
- Regulation 44
- Statutory regulation and inspection- currently overcomplicated , fragmented and poorly understood

CSPR 2 – external oversight…..

- **Intelligence about concerns at Hesley Doncaster January 2018 to March 2021**
  - 20 whistleblowing occurrences.
  - 31 formal complaints from placing local authorities.
  - A full series of monthly Regulation 44 visit reports.
  - 108 Regulation 40 incident notifications to Ofsted.
  - 61 hospital referrals.
  - 232 LADO referrals
- Ofsted were the SINGLE agency receiving all of this information and *"Over the period from 2018 to 2021, intelligence available from complaints, allegations and inspection evidence was not brought together with sufficient rigour to identify risk at the three settings and escalate earlier intervention."*
- PRACTICE- are you monitoring for themes ? Acting on learning ? Undertaking root cause analysis? Is your RI monitoring effectively ? Is your R44 effective? Is the LADO robust in response ? Do you challenge the LADO when needed ? Is whistleblowing embedded in your culture ? Are you using R40 effectively? Does your R45 indicate actions taken with measurable outcomes and impact?

Regulation 44……

- "To ensure greater effectiveness and consistency in the independent visitor role, it should be a requirement that those appointed to the role have skills and experience relevant to the children and the type of home. The scope of the role should include a requirement for the visitor to raise significant concerns directly with the regulator and the placing local authority.
- There was strong support at our round table events for independent visitors to be appointed through an independent commissioning body. This could be through a national children's organisation or charity".

- Currently- Dialogue working with a group to look at guidance- including Dfe

CSPR 2- external oversight…

- **Recommendation**
  The DfE and DHSC should (a) review and revise the regulatory framework for residential settings to reduce complexity and improve the impact of the current arrangements for monitoring, quality assurance and oversight; (b) take immediate steps to establish arrangements for joint inspection by Ofsted and CQC of residential settings for children with disabilities and complex health needs

- Should have an outcome June / July 2024

- Pp. 80-83
- Finally, recognition of the need for inspection by professionals with experience in this field as well as the inspection of the overarching organisations

CSPR phase 2.....

National recommendations (pp84 and onwards) also include:

1. access to specialist independent advocacy for the children (also ICR)

2. independent advice for children and families when a long-term residential placement is being considered;

3. statutory requirements for local authorities and integrated care boards (ICBs) to jointly commission safe, sufficient and appropriate local provision (also ICR)

4.a new strategy to address longstanding workforce challenges

5.enhanced oversight of safeguarding risks by host local authorities and ICBs.

Final comment from the report:

- ***Residential settings need to be places where children feel loved, safe and cared for. We hope that the legacy of this review will be just that. The changes proposed here will enable a step change in how we meet the needs of this group of children, but we know too, that there is much more to be done in the longer term to enable these children to live the lives they want and should be able to have.***

Closed cultures and their context/ indicators

- How would you know if you had an issue?

Context:

- The culture of the setting sets the scene for all aspects of the provision and within this must sit a clearly defined , well structured , recognisable TO ALL secure safeguarding culture.

dialogue

Starting point:

- Maybe a team meeting discussion “what does a “closed culture “ mean to you ?”
- It is important to remember that generally , no-one sets out to harm….. but, closed cultures can lead to significant harm

- Some indicators …..

dialogue

Closed cultures…

- are one of the biggest of safeguarding risks and as seen the CSPR 1and Phase 2 reports can contribute to serious and significant harm for children and young people.

- As a senior leader what should you look out for ?

❖Poor experience of children who should be safeguarded and their well being supported and promoted

❖Weak leadership and management

❖Limited or no external input , review , alignment

Closed cultures……

Features:

- Children are at risk of deliberate or unintentional harm-how can unintentional harm occur and become common and accepted practice ?
- Leaders / staff stop seeing or have never seen the true situation re. safeguarding in the setting-why ?
- Children / staff are unable or afraid to speak up for themselves and are not listened to if they do-how ?
- There may be high levels of dependence on some staff/ HT /RM/others- why is this worrying ?
- There may be breaches of human rights and equality law-how ?

dialogue

Closed cultures…..

- Poor skills, experience and training of staff / leaders
- There are regular changes in leadership roles-why ?
- There is a high staff turnover- across the board
- High frequency of staff absence / leadership & SLT absence / illness
- Cliques-these can be especially dangerous ?
- Staff are not supported or encouraged to raise concerns.
- SLT fail to monitor, and address issues raised by staff, ,children , families and others-why ?
- SLT fail to respond to recommendations of others, for example professionals and regulators.

Closed cultures

- There is a high use of agency/cover staff
- There is a lack of suitable induction, training, monitoring and supervision of staff.

dialogue

Closed cultures…..

External oversight..

- Is there a high or increasing number of safeguarding incidents, complaints or other notifications? Especially concerning if they involve:
- any form of inappropriate behaviour by staff towards children / young people
- complaints by children / young people using the service, their family and friends, including those that are withdrawn subsequently.
- Anything else ?

Lots to review and reflection is key…

- Any causes for concern ?
- Are any of these issue causing you concern in terms of monitoring / review in the home?
- Stability of the staff team?
- Skills base of the staff team?
- Skills of leaders and managers ?

- How can a service detect / avoid such a culture becoming established ?

CSPR links

- https://www.gov.uk/government/news/experts-demand-major-overhaul-of-safeguarding-system-to-protect-children-with-disabilities-from-abuse-at-childrens-homes
- https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1151060/Safeguarding_children_with_disabilities_in_residential_care_homes_phase_2_report.pdf

- All relevant links within this document

dialogue

Lots to think about:

- Next session we will look at models and issues arising in measuring progress for our young people – an essential element of care and support and a key indicator for the regulator.

- See you then . Chris