



**ADCS Survey of Local Safeguarding Children
Board Chairs:
The Effectiveness and Influence of
Designated Leads for Safeguarding and Looked
after Children in the NHS**

Key findings

On vacancy rates:

- Vacancy rates for safeguarding nurses in 2011 of 11.1%, for safeguarding doctors of 14% and for designated Looked After Children professionals of 22%;
- Since 2009 vacancy rates have risen in all three types of role:
 - from 5% in 2009 to 11% in 2011 for safeguarding nurses;
 - from 3.8% to 14.4% for safeguarding doctors; and
 - from 19% to 22% for designated Looked After Children professionals.

On factors affecting the effectiveness of support offered to the LSCB:

- 33% of responding LSCB Chairs felt that vacancies had reduced the effectiveness of support for the LSCB;
- 25% felt that the transition process had reduced effectiveness;
- 25% attributed any increase in effectiveness to the individual commitment of the designated lead.

On factors affecting influence on decision making in the NHS:

- 33% reported that moving from a provider to a commissioning arm of the NHS had increased influence;
- 24% felt that either the transition process or the consequences of structural change had diminished influence of the designated safeguarding leads;
- 15% felt that a local focus on safeguarding in the PCT had helped improve influence;
- 15% felt that the national focus on safeguarding in health services had helped improve influence;

On the future:

- 57% of respondents thought the designated safeguarding roles should be commissioned by the Health and Wellbeing Boards in future;
- 20% noted that designated safeguarding leads are crucial for partnership working;
- 16% expressed concern about designated leads having additional roles;
- 16% expressed a need for a statutory duty on health or statutory guidance relating to the role to ensure safeguarding remains a priority in the NHS;

1. Introduction

This report summarises the results of a survey of Local Safeguarding Children Board Chairs regarding designated safeguarding and looked after children professionals in the NHS. The Children Act 2004 placed a duty to co-operate in developing and delivering services for children on PCTs and local authorities. Subsequent statutory guidance laid out requirements for PCTs in England to appoint designated professionals to advise the PCT on safeguarding and looked after children services and to sit on the Local Safeguarding Board. The purpose of the survey was to identify how influential the roles have been over the last three years and what elements affect the ability of designated leads to fulfil their role, and how the roles should be sustained in the new arrangements for the NHS.

• **Designated safeguarding professionals**

The guidance on the role contained in Working Together to Safeguard Children describes the responsibilities of the PCT regarding the appointment of designated leads including ensuring that:

- *“establishment levels of designated and named professionals are proportionate to the local resident populations and to the complexity of provider arrangements.”;*
- designated roles are *“explicitly defined in job descriptions”;* and
- *“Sufficient time, funding, supervision and support [are] allowed to fulfil their child safeguarding responsibilities effectively”¹.*

Individual designated safeguarding professionals:

- provide advice to ensure the range of services commissioned by the PCT take account of the need to safeguard and promote the welfare of children;
- provide advice on the monitoring of the safeguarding aspects of PCT contracts;
- provide advice, support and clinical supervision to the named professionals in each provider organisation;
- provide skilled advice to the LSCB on health issues;
- play an important role in promoting, influencing and developing relevant training, on both a single and inter-agency basis, to ensure the training needs of health staff are addressed;
- provide skilled professional involvement in child safeguarding processes in line with LSCB procedures; and
- review and evaluate the practice and learning from all involved health professionals and providers commissioned by the PCT, as part of Serious Case Reviews.

Serious case reviews and inspectors' reports have both highlighted the importance of health professionals and commissioners being able to access advice on safeguarding issues².

¹ Working Together to Safeguard Children. Department For Children, Schools and Families. 2010.

² Review of the involvement and action taken by health bodies in relation to the case of Baby P . Care Quality Commission. May 2009.

Professor Munro, in her final report into the Child protection system in England, notes that designated safeguarding professionals in health “*facilitate effective engagement and dialogue for... health professionals as well as providing a single, senior point of contact for local partners. They are critical for the identification and delivery of help to children, young people and their families*”³.

- **Designated professionals for Looked After Children**

Looked After Children not only require equal access to health services as those provided for their peers not in the care of the local authority, but may also have specific health needs that local authorities should address as part of their corporate parenting responsibilities. These might include specialist behavioral support or help with disabilities or mental health problems resulting from their experiences prior to coming into care. In addition, access to universal health services such as dentistry is often complicated by moves between placements and a mistrust of health professionals.⁴

Designated professionals for Looked After Children are doctors and nurses with “*responsibility for looked-after children and young people and an understanding of their particular healthcare needs. They have the authority to make things happen both for an individual child and for looked-after children generally in their locality. They also have a strategic role to assist commissioners of health services to fulfill their responsibilities to meet the needs of looked-after children and young people. The post holders may monitor commissioned services or provide direct services to individual children.*”⁵

- **Why undertake this research now?**

The risks presented by current turbulence in the health service due to national policy changes and by the fragmentation of services proposed in the pending Health and Social Care Bill were also noted by Professor Munro. Her recommendation, accepted and expanded by government, was for research to be undertaken jointly by the Department of Health and the Department for Education into the consequences of changes to the commissioning and delivery of health services for child protection⁶. This report seeks to contribute to that research effort by investigating the views of LSCB chairs on the future of the roles of designated safeguarding and Looked After Children professionals within the NHS.

2. Methodology

³ Munro Review of Child Protection: Final Report – A child centred system (p58)

⁴ Statutory Guidance on Promoting the health and wellbeing of looked After Children. Department of Children, Schools and Families. November 2009.

⁵ Promoting the quality of life of looked-after children and young people. NICE/SCIE guidance. September 2010.

⁶ Government Response to the Munro Review of Child Protection in England – add ref.

A standardised survey was sent to all 147 LSCB chairs via Directors of Children's Services and via the Independent LSCB Chair network. 69 responses were received, giving a 48% response rate. The survey included closed questions and free text questions for further comment. Respondents were asked about historic and current vacancy rates for designated leads for both safeguarding and Looked After Children; changes to influence within the NHS; the effectiveness of the support provided to the LSCB by designated safeguarding leads; and their views on the how these roles should be commissioned in future. 2009 was selected as a baseline year to assess the effect of recent changes in the NHS on the designated professionals – prior to the clustering of PCTs and to announcements on resource reduction since the General Election 2010.

3. Key Findings

- **Vacancy rates**

Respondents were asked about the number of full time equivalent posts that should have been filled in each year and the number of vacancies in 2009, 2010 and 2011. The average vacancy rate for each year was calculated as a percentage of posts in the given year for safeguarding nurses, safeguarding doctors and LAC professionals.

Vacancy rates were substantially higher for Designated Looked After Children leads than for either of the designated safeguarding posts in all three years. The number of full time equivalent posts allocated to designated safeguarding and Looked After Children roles remained the same or increased for all three types of post. Vacancy rates increased for all three types of role: for safeguarding nurses (from 5% to 11%); for safeguarding doctors (from 3.7% to 14.4%); and for designated Looked After Children professionals (from 19.2% to 21.9%).

17% of respondents reported one or more vacancies in one of the three roles in 2009, 24% in 2010 and 27% in 2011. 3 LSCBs had no designated safeguarding or LAC leads in 2011, compared to none in 2010 and 2009.

Respondents reported that vacancies had affected the influence of the designated leads on decision making in the PCT (7%) and on the effectiveness of service to the LSCB (33%). Of those who reported one or more vacancies since 2009, 23% reported that vacancies had affected either influence in the PCT or effectiveness of support for the LSCB.

- **Additional Roles**

41 (60% of respondents) LSCB Chairs reported that one or more of the designated safeguarding or LAC professionals in their area fulfilled another statutory role, such as leading on adult safeguarding, holding responsibility for public health for children in need, child protection and looked after children or held both the LAC and safeguarding role.

- **Seniority and influence within the NHS**

Respondents were asked the current grade of the safeguarding nurse, doctor and both LAC professionals. The majority of doctors for both safeguarding and LAC were consultants, but the average grade of a safeguarding nurse was higher (grade 8) than the Looked After Children nurse (grade 7).

Respondents were then asked to rate the influence of the safeguarding professionals on a scale of 1-4, with 1 being not at all influential and 4 being very influential. On average, the 67 respondents considered that designated safeguarding leads were influential (3 out of a possible 4) on decision making in the PCT. The majority of respondents (76%) reported that the designated safeguarding leads were influential or very influential on decision making. When asked whether that influence had changed in the last year, over half (55%) reported increased influence and (29%) reported a decrease in influence.

A free text box was provided for respondents to comment on the reasons why the level of influence had changed. Of those reporting that influence had increased, 33% felt that this could be attributed at least in part to the designated safeguarding leads moving to the commissioning, rather than provider arm of the PCT. One in five reported that this was a result of an increased focus on safeguarding within the NHS, either locally (22%) or nationally (22%). For 16%, the increased seniority of the designated lead had resulted in increased influence within the PCT.

Of those reporting a decrease in influence, 43% felt that this was due to structural change within the health service and 35% attributed the decrease to the transition process. 21% of these felt that vacancy rates, a decrease in seniority of the designated safeguarding lead or the move from provider to commissioner had caused a decrease in influence.

- **Effectiveness of service to the LSCB**

Respondents were asked to rate the effectiveness of the advice provided to the LSCB by the designated safeguarding leads, again on a scale of 1-4, with 1 being a poor level of service and 4 being an excellent level of service. The average effectiveness of support for the LSCB was higher than the influence within the PCT – with an average rating of 3.7. 90% of respondents rated the effectiveness of the designated safeguarding lead as good (3) or excellent (4).

20% of respondents felt that the effectiveness of advice had increased in the last year while 15% reported a decrease in effectiveness, the remainder of respondents reported no change. When asked about the possible reasons for change in effectiveness, of those who felt that effectiveness had increased, 50% reported that this was down to the commitment of the individual in post at the time, 25% reported that the LSCB itself had been more focussed on health issues and 25% reported that the LSCB adopting an outcome focussed approach to their work had increased the effectiveness of support provided by the designated safeguarding lead.

Of those reporting a decrease in effectiveness, 88% reported vacancies as one cause of the decline, 66% blamed the transition process and 11% a reduction in resources.

- **Future Commissioning arrangements**

In the context of changes to commissioning responsibilities within the NHS, respondents were asked for their views on who should commission the designated safeguarding leads in future. The questionnaire noted that safeguarding leads would continue to be employed by the health service, however, they were commissioned.

73% favoured a local commissioning option, with 57% stating that the posts should be commissioned jointly by the local authority and clinical commissioning groups through the Health and Wellbeing Board. 23% thought that clinical commissioning groups alone should commission the posts and 17% thought that the National Commissioning Board should hold this responsibility.

Respondents were given the opportunity to make any further comments on the future commissioning arrangements for designated safeguarding leads in a free text box.

- **Value of the role**

32% of respondents to this question stated how highly they valued the roles and that they should be retained. 20% highlighted the key contribution that designated professionals make to partnership working between the health service and the local authority.

- **Guidance**

16% were concerned about the designated safeguarding leads holding additional roles, with 6 mentioning the adult safeguarding role in particular. 16% also called for a duty on health bodies to promote safeguarding, and 16% called for statutory guidance on the role itself.

- **Influence**

12% noted that the need for safeguarding to be considered in commissioning health services was important and 12% noted that GPs would require increasing amounts of assistance in their new commissioning role to take full account of safeguarding issues. Respondents were aware of the tension between the need for the role to be able to influence every part of the health service (12%) and the need for the role to be aware of, and be able to take into account, local circumstances (12%).

4. Conclusions

The survey results present a mixed picture of the service provided by designated safeguarding and LAC professionals. While there is some evidence that PCTs and the NHS nationally have

improved their focus on children's safeguarding in recent years, this has not prevented vacancy rates from rising. There is no doubt that LSCB chairs strongly value the designated roles with 32% noting the importance of retaining the role in the future. This is confirmed by the high scores given for the effectiveness of service provided to the LSCB and for influence on decision making in the PCT. More specifically, respondents noted the key role for the designated leads in supporting partnership working and in supporting commissioning of services.

- **Focus on safeguarding in the health service**

The rise in the number of full time equivalent posts in all three types of role since 2009 indicates an increased appreciation of the importance of these roles in the last three years. This is supported by respondents who noted that the increased focus on safeguarding locally and nationally within the NHS had improved the influence of the designated leads on decision making within the health service.

- **Effect of vacancies**

Despite the increase in posts, vacancies have increased over and above the increase in posts, suggesting that PCTs are struggling to fill existing and new posts. The increase in vacancies since 2009 is dramatic with vacancy rates for safeguarding nurses increasing by 123% since 2009 and vacancy rates for safeguarding doctors nearly three times higher in 2011 than in 2009. This is affecting the quality of service to the LSCB according to a third of LSCB chairs who have experienced vacancies.

- **Capacity**

The introduction of designated safeguarding roles for adults is causing concern among LSCB chairs that the same individual should not fulfil both roles. This concern is rooted in experience of the erosion of the capacity of individual designated professionals to perform their duties, as well as cover absence due to sickness or provide networking opportunities to improve practice. A majority of respondents reported that the designated professionals on their LSCB are already fulfilling other roles, including that of designated adult safeguarding lead. LSCB chairs also note that designated safeguarding professionals will have more demands on their time, and therefore require additional capacity, if GPs take on responsibility for commissioning children's health services.

- **Transition and structural change within the NHS**

The process of moving to new arrangements for managing the designated leads, and wider changes with the health service are having an impact on the ability of designated professionals to perform their role effectively. The disruption caused by transition was mentioned as having a negative effect on influence within the health service and on effectiveness of support to the LSCB.

Views on the effect of the new arrangements themselves, rather than the process of moving from one arrangement to another, are more mixed with one in five identifying a positive effect,

with another one in five noting a negative effect on influence within the health service and on effectiveness of service to the LSCB.

- **Future arrangements**

It is clear that the roles of the designated professionals are highly valued and should continue to form part of the infrastructure supporting the consideration of safeguarding issues across the multi-agency partnership of the Local Safeguarding Children Board. The vast majority of LSCB chairs (73%) call for these roles to be commissioned locally, with more than half seeing the health and wellbeing board as the preferred option, as representing both clinical commissioning groups and the local authority.

Some LSCB chairs (12%) were concerned that the designated leads should be able to influence all parts of an increasingly fragmented health system and this may explain the 18% who called for designated professionals to be commissioned by the National NHS Commissioning Board. However, more (16%) felt that statutory guidance on the role or a duty to consider safeguarding when commissioning health services would provide designated safeguarding leads with sufficient influence.