

HAMPSHIRE COUNTY COUNCIL**Report**

Committee/Panel:	Children and Families Advisory Panel
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Summary

The purpose of this paper is to outline to Children and Families Advisory Panel the progress achieved by Hampshire Children's Services against the Munro Review of Child Protection.

1. Key points from the Munro Review of Child Protection

1.1 The Review of Child Protection undertaken by Professor Eileen Munro comprised three reports which provided an analysis of the current child protection system and recommendations for improvement. The analysis identified the system as 'defensive' and driven by four key forces:

- The strong public reaction when a child is killed or seriously injured
- A belief that complexity and uncertainty in child protection work can be eradicated
- A readiness in high profile enquires to focus on professional error
- Undue importance given to performance indicators and targets which have skewed attention towards process rather than quality and effectiveness

1.2 Key themes were identified in relation to the impact on capacity and competence of social workers. Looking specifically at the recommendations for reform of social work practice within local authority children's services, the Munro Review identified the following key points:

- A recognition that preventative and early intervention services can do more to reduce abuse and neglect than reactive services – therefore a focus on early help
- A reduction in bureaucratic processes and demands of record keeping in order to reduce time spent in the office and increase capacity of social workers to work directly with children and families
- The need for an improvement in expertise of social workers and a drive to enable them to exercise their professional judgement. This will demand a significant improvement in knowledge, use of research evidence and skills of social workers
- Encouragement for organisations to move from a compliance culture to a learning culture
- The employment of critical reflection as a learning process – promoting more feedback loops to monitor how the system is working and address any unintended consequences
- Children’s services to establish a designated Principal Child and Family Social Worker
- Regular case review (not just for child deaths) using the systems model to provide a window on practice across the organisation
- The use of national and local indicators to determine performance, facilitate improvement and promote accountability

1.3 The Munro Review was clear that many of these intentions could not be realised without considerable changes to structures, systems and skill levels. The full range of recommendations is attached as Appendix 1. All of the recommendations were accepted by government either in full or in principle although the full detail of the activity that will be required by central and local government is still awaited in some cases. For example, the government is still consulting on revised performance frameworks and as yet no revision of the key statutory guidance (‘Working Together to Safeguard Children’) has emerged.

1.4 This report will focus on these recommendations that relate fully or in part to the responsibilities of the local authority. I have grouped the recommendations and listed them in a rough order of importance.

2. System redesign

Recommendation 13: Local authorities and their partners should start an ongoing process to review and redesign the ways in which child and family social work is delivered...

Recommendation 10: The Government should place a duty on local authorities

and statutory partners to secure the sufficient provision of local early help services for children, young people and families...

Recommendation 14: Local authorities should designate a Principal Child and Family Social Worker, who is a senior manager with lead responsibility for practice in the local authority

- 2.1 Hampshire Children's Services have begun a process to review and redesign children's social work services. We have worked with the independent chair of the Hampshire Safeguarding Children Board (HSCB) to assess our current service design and we are in the process of developing a detailed specification for a pilot based on the 'redesigning social work' principles that have been running in some local authorities (Hackney, Cambridgeshire) and which were highlighted in the Munro report. We have identified that the first area to pilot will be Basingstoke and we will identify an area in the East of the county in due course. We have also carried out three workshops with front line staff to assess their views on the likely building blocks and barriers for service redesign. It is likely that we will keep our essential building blocks (Referral and Assessment, Children in Need, Children in Care) which have proven to be successful, but that the redesign will focus on the structure of the teams within these building blocks. All concerned are clear that this redesign will need to be delivered at no additional cost. There is some evidence to show that in areas that have adopted such new ways of working, more effective social work interventions have led to an overall reduction in costs, for example children in care. This should be treated with caution though, given that those redesigns were often brought in as a result of particular problems with service delivery and it is arguable that other interventions which led to greater managerial grip would have also had similar impact.
- 2.2 Although not an explicit recommendation from the Munro review, there is a clear expectation that local authorities will work towards reducing the bureaucratic burden on social workers. Our own social work survey indicates that this burden is very high in Hampshire and is leading to unsustainable working patterns and stress. A procurement process is underway to procure an effective social care IT system.
- 2.3 Similarly, whilst not an explicit recommendation from Munro, a number of areas (including for example, all London boroughs) are developing multi-agency safeguarding hubs (MASH). These co-locate social workers, police and health professionals in order to effectively share information and triage referrals in order to ensure that child protection is more effectively targeted. We have had early discussions with Hampshire Constabulary and Southern Health on this matter. There is some variation of approach

between the other three Hampshire local authorities and at one stage it appeared that police wanted one system. However, we are now progressing discussions with a view to developing a MASH at Hantsdirect. The police have revised their policy on forward CYPs (the documentation relating to any interaction with a child or young person) which has reduced the number of documents transferred down from 3,000 per month.

- 2.4 Another facet of social work redesign was Munro's interest in a single assessment document. This did not eventually become a recommendation but a number of authorities have looked into this. In reality, from my discussions with a number of authorities, none of them are doing anything dramatically different with some of them conflating initial and core assessments. Others have thought about family based assessments but there has been little evidence of this being progressed thus far. In any case, we would be unable to progress a single assessment further in Hampshire with the current IT system available. This is therefore effectively 'parked' until we can make progress in identifying a new software supplier.
- 2.5 With regards to the duty to secure early help, Hampshire Safeguarding Children Board have recently commissioned a project to scope the range and effectiveness of early help provision in Hampshire. This report which will return to the HSCB in September will make recommendations that should ensure that there is sufficient provision of early help in Hampshire. Related to this topic is the current consultation and potential redesign of locality teams which may lead to improved early help for vulnerable children, although there are also some potential risks, particularly with regards to funding. Similarly the redesign of children's centres provides an opportunity to establish better support for vulnerable children.
- 2.6 The Principal Social Worker role (recommendation 14) has been the subject of some debate. Coincidentally, and funded primarily by Social Work Improvement Fund moneys, we have appointed 4 additional workforce development officers (WDOs) and a lead WDO who will manage this service. These officers, along with the 4 existing WDOs, will report to the Workforce Development Team and will be responsible for offering reflective supervision to newly qualified social workers (as opposed to line management supervision which will remain within the team), expanding our capacity to offer practice placements, developing and improving practice within teams by facilitating good practice workshops etc. The lead WDO will be in a good position, both structurally and pragmatically, to fulfil the role of the Principal Social Worker. Therefore this post has been advertised as such. The post holder will provide a report to CFMT on a quarterly basis

which will outline the issues that front line practitioners are raising – in line with the recommendation of the Munro report.

3. Inspection and Regulation

Recommendation 3: The new inspection framework should examine the child's journey from needing to receiving help...

- 3.1 Ofsted have announced that there will be a one year programme of unannounced two week inspections of safeguarding for 2012/13. Ofsted have said that it is unlikely that all authorities will be inspected under these new, one year arrangements (indeed it would be impossible for them), instead 'The selection of local authorities for inspection will take account of: previous inspection outcomes; information from other sources, such as whistleblowing referrals, complaints, and serious case reviews; and any other relevant information.'
- 3.2 Looking ahead, Ofsted are working on a multi-agency inspection framework as recommended in the Munro review. The Deputy Director (Children and Families) has been invited to take part in a small working group which will assist in the design of this framework. It is anticipated that this will be in place for 2013 onwards.
- 3.3 Clearly though, it remains sensible for us to be prepared for inspection at any time both for the purposes of being able to respond in the event of the real thing; and also because it is good for us to constantly test ourselves to ensure that we are continuing to deliver high quality services.
- 3.4 To this end, we have arranged a series of 3 day, unannounced, internal peer inspections. East will inspect West and vice versa. These will be carried out on a rolling programme from May/June 2012. the results will be evaluated and fed into future self assessments and service plans, in line with the Quality Improvement Plan. These peer inspections will be guided by and use, in so far as is possible, the Ofsted framework for inspection in order that we are preparing for future inspections. In particular the inspections will identify some children's cases and 'follow the journey of the child', as recommended by Munro.

4. Performance Management

Recommendation 4: Local authorities and their partners should use a combination of nationally collected and locally published performance information...

- 4.1 In many ways this is the least developed aspect of our response to the Munro review. Primarily because the Department for Education have embarked on a lengthy consultation process with regards to a new performance framework. This consultation closed on 16 April although obviously the results have not yet been published. A summary of the somewhat onerous performance measures is attached as Appendix 2. It should be stressed that these performance measures do not include other aspects of children's social care such as children in care and adoption.
- 4.2 In order to maintain a focus on performance, management have developed plans to restructure our county wide Performance Action Group (PAG) and the way in which we report performance to this. When the final performance measures are announced we have identified a group of practitioners to assist us in translating the measures into meaningful 'bundles' and establishing which will be the key drivers for overall performance. CSDMT have also approved a revised performance manager role, constituted from various other roles which will assist in supporting this piece of work.
- 4.3 CFMT have assisted in the development of the CYPP which will reflect the developments outlined in this paper. As ever, service plans will continue to reflect these developments. Quality assurance monitoring continues as previously with team, district and area managers auditing case files across the service on a monthly basis. This is collated and reported to CFMT for any action required on a quarterly basis.

5. Governance

Recommendation 5: The existing statutory requirements for each Local Safeguarding Children Board (LSCB) to produce and publish an annual report for the Children's Trust Board should be amended, to require its submission instead to the Chief Executive and Leader of the Council, and, subject to the passage of legislation, to the local Police and Crime Commissioner and the Chair of the Health and Wellbeing Board.

Recommendation 6: The statutory guidance, *Working Together to Safeguard Children*, should be amended to state that when monitoring and evaluating local arrangements, LSCBs should, taking account of local need, include an assessment of the effectiveness of the help being provided to children and families (including the effectiveness and value for money of early help services, including early years provision), and the effectiveness of multi-agency training to safeguard and promote the welfare of children and young people.

Recommendation 7: Local authorities should give due consideration to protecting the discrete roles and responsibilities of a Director of Children's

Services and Lead Member for Children's Services

- 5.1 The Hampshire Safeguarding Children Board has produced its annual report in line with the current guidance. At this stage, legislation has not yet been changed to create the requirement to submit the report to the Chief Executive and Leader of the Council and, in due course, the chair of the Health and Wellbeing Board. Such arrangements can be put in place relatively quickly upon the passing of the statutory instrument.
- 5.2 As set out above, the HSCB has already commissioned a piece of work to evaluate the effectiveness and scope of current early help provision (recommendation 6) and the effectiveness if multi-agency training is monitored through the HSCBs Learning and Development subgroup which reports in to the main Board.
- 5.3 Finally, new guidance has been issued by the DfE on the role of the Director of Children's Services and the role of the Lead Member. Initial reading indicates that Hampshire remains compliant with this guidance although a more thorough exercise needs to be carried out to assure the County Council of this compliance. This will be carried out in the near future.

6. Learning and Development

Recommendation 9: The Government should require LSCBs to use systems methodology when undertaking Serious Case Reviews (SCRs)

Recommendation 12: Employers and higher education institutions (HEIs) should work together so that social work students are prepared for the challenges of child protection work....

- 6.1 With regards to Serious Case Reviews (SCRs), Hampshire has had no SCRs in the period since the Munro review. If and when such a review is required (and statistically, it is a matter of when) then the review will be commissioned from an independent author who has been trained in the new methodology. The numbers of such independent authors is growing and there is further training being rolled out. The nature of the independence required means that there would be little benefit in training our staff to carry out this function (they are not independent by definition). Two small scale reviews have been carried out, where the criteria for SCR have not been met but where there was felt to be some useful learning from a review of the work carried out. These have both used the new methodology and, from the one early feedback has been positive.

- 6.2 As stated above, Hampshire Children's Services have put in place significant additional resource, funded from the Social Work Improvement Fund, in order to increase and improve our capacity to work together more effectively with higher education institutions in order that social work students are better prepared for child protection work. The Workforce Development Team continue to work closely and effectively with CFMT to develop learning pathways for social workers. One example of this is the commissioning of Community Care Inform system after a successful trial. This system provides social workers with an online reference resource to assist in practice, decision making and court work.
- 6.3 Links with HEIs have been formed and we are in the process of identifying link DMs for each of the social work courses. Over the last few years we have also established a good working relationship with Bournemouth University with regards to continuing professional development for front line managers in particular as they have provided bespoke training for our team managers and assistant team managers. Finally, we have continued to ensure that up to 8 staff per year have access to social work training via the Open University in our 'grow your own' scheme.

7. Conclusion

- 7.1 This paper sets out the challenges posed by the Munro review of child protection and the response to those challenges by Hampshire Children's Services. For all of the recommendations that pertain to the local authority we have a plan in place to deliver the improvements expected. Those plans are proportionate, appropriately cautious but also open to new ideas where these may better protect children.

8. Recommendation

The Panel note the content of this report and progress against the recommendations made by Professor Munro.

CORPORATE OR LEGAL INFORMATION:

Links to the Corporate Strategy

Hampshire safer and more secure for all:	yes/æ
Corporate Improvement plan link number (if appropriate):	
Maximising well-being:	yes/no
Corporate Improvement plan link number (if appropriate):	
Enhancing our quality of place:	yes/no
Corporate Improvement plan link number (if appropriate):	

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document

Location

None

IMPACT ASSESSMENTS:

1. Equalities Impact Assessment:

1.1. No impact

2. Impact on Crime and Disorder:

2.1. No impact

3. Climate Change:

- a) How does what is being proposed impact on our carbon footprint / energy consumption?

- b) How does what is being proposed consider the need to adapt to climate change, and be resilient to its longer term impacts?

Summary of recommendations

Chapter three: A system that values professional expertise

Recommendation 1: The Government should revise both the statutory guidance, *Working Together to Safeguard Children* and *The Framework for the Assessment of Children in Need and their Families* and their associated policies to:

- distinguish the rules that are essential for effective working together, from guidance that informs professional judgment;
- set out the key principles underpinning the guidance;
- remove the distinction between initial and core assessments and the associated timescales in respect of these assessments, replacing them with the decisions that are required to be made by qualified social workers when developing an understanding of children's needs and making and implementing a plan to safeguard and promote their welfare;
- require local attention is given to:
 - timeliness in the identification of children's needs and provision of help;
 - the quality of the assessment to inform next steps to safeguard and promote children's welfare; and
 - the effectiveness of the help provided;
- give local areas the responsibility to draw on research and theoretical models to inform local practice; and
- remove constraints to local innovation and professional judgment that are created by prescribing or endorsing particular approaches, for example, nationally designed assessment forms, national performance indicators associated with assessment or nationally prescribed approaches to IT systems.

Recommendation 2: The inspection framework should examine the effectiveness of the contributions of all local services, including health, education, police, probation and the justice system to the protection of children.

Recommendation 3: The new inspection framework should examine the child's journey from needing to receiving help, explore how the rights, wishes, feelings and experiences of children and young people inform and shape the provision of services, and look at the effectiveness of the help provided to children, young people and their families.

Recommendation 4: Local authorities and their partners should use a combination of nationally collected and locally published performance information to help benchmark performance, facilitate improvement and

promote accountability. It is crucial that performance information is not treated as an unambiguous measure of good or bad performance as performance indicators tend to be.

Chapter four: Clarifying accountabilities and improving learning

Recommendation 5: The existing statutory requirements for each Local Safeguarding Children Board (LSCB) to produce and publish an annual report for the Children's Trust Board should be amended, to require its submission instead to the Chief Executive and Leader of the Council, and, subject to the passage of legislation, to the local Police and Crime Commissioner and the Chair of the health and wellbeing board.

Recommendation 6: The statutory guidance, *Working Together to Safeguard Children*, should be amended to state that when monitoring and evaluating local arrangements, LSCBs should, taking account of local need, include an assessment of the effectiveness of the help being provided to children and families (including the effectiveness and value for money of early help services, including early years provision), and the effectiveness of multi-agency training to safeguard and promote the welfare of children and young people.

Recommendation 7: Local authorities should give due consideration to protecting the discrete roles and responsibilities of a Director of Children's Services and Lead Member for Children's Services before allocating any additional functions to individuals occupying such roles. The importance, as envisaged in the Children Act 2004, of appointing individuals to positions where they have specific responsibilities for children's services should not be undermined. The Government should amend the statutory guidance issued in relation to such roles and establish the principle that, given the importance of individuals in senior positions being responsible for children's services, it should not be considered appropriate to give additional functions (that do not relate to children's services) to Directors of Children's Services and Lead Members for Children's Services unless exceptional circumstances arise.

Recommendation 8: The Government should work collaboratively with the Royal College of Paediatrics and Child Health, the Royal College of General Practitioners, local authorities and others to research the impact of health reorganisation on effective partnership arrangements and the ability to provide effective help for children who are suffering, or likely to suffer, significant harm.

Recommendation 9: The Government should require LSCBs to use systems methodology when undertaking Serious Case Reviews (SCRs) and, over the coming year, work with the sector to develop national resources to:

- provide accredited, skilled and independent reviewers to jointly work with LSCBs on each SCR;
- promote the development of a variety of systems-based methodologies to learn from practice;
- initiate the development of a typology of the problems that contribute to adverse outcomes to facilitate national learning; and

- disseminate learning nationally to improve practice and inform the work of the Chief Social Worker (see chapter seven).

In the meantime, Ofsted's evaluation of SCRs should end.

Chapter 5: Sharing responsibility for the provision of early help

Recommendation 10: The Government should place a duty on local authorities and statutory partners to secure the sufficient provision of local early help services for children, young people and families. The arrangements setting out how they will do this should:

- specify the range of professional help available to local children, young people and families, through statutory, voluntary and community services, against the local profile of need set out in the local Joint Strategic Needs Analysis (JSNA);
- specify how they will identify children who are suffering or who are likely to suffer significant harm, including the availability of social work expertise to all professionals working with children, young people and families who are not being supported by children's social care services and specify the training available locally to support professionals working at the frontline of universal services;
- set out the local resourcing of the early help services for children, young people and families; and, most importantly
- lead to the identification of the early help that is needed by a particular child and their family, and to the provision of an "early help offer" where their needs do not meet the criteria for receiving children's social care services.

Chapter 6: Developing social work expertise

Recommendation 11: The Social Work Reform Board's Professional Capabilities Framework should incorporate capabilities necessary for child and family social work. This framework should explicitly inform social work qualification training, postgraduate professional development and performance appraisal.

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Recommendation 12: Employers and higher education institutions (HEIs) should work together so that social work students are prepared for the challenges of child protection work. In particular, the review considers that HEIs and employing agencies should work together so that:

- practice placements are of the highest quality and – in time – only in designated Approved Practice Settings;
- employers are able to apply for special 'teaching organisation' status, awarded by the College of Social Work;
- the merits of 'student units', which are headed up by a senior social worker are considered; and
- placements are of sufficiently high quality, and both employers and HEIs consider if their relationship is working well.

Chapter 7: The organisational context: supporting effective social work Practice

Recommendation 13: Local authorities and their partners should start an ongoing process to review and redesign the ways in which child and family social work is delivered, drawing on evidence of effectiveness of helping methods where appropriate and supporting practice that can implement evidence based ways of working with children and families.

Recommendation 14: Local authorities should designate a Principal Child and Family Social Worker, who is a senior manager with lead responsibility for practice in the local authority and who is still actively involved in frontline practice and who can report the views and experiences of the front line to all levels of management.

Recommendation 15: A Chief Social Worker should be created in Government, whose duties should include advising the Government on social work practice and informing the Secretary of State's annual report to Parliament on the working of the Children Act 1989.

From the Munro report

Government has consulted on the following measures that relate to child protection (in the broadest sense)

Nationally collected data set

- 1) Rate of violent and sexual offending against young people
- 2) Hospital admissions caused by injury (and new item of hospital admissions as a result if physical, emotional, sexual abuse and neglect)
- 3) A & E admissions for assault and self harm for children
- 4) Educational attainment of children in need including new data around level 4 KS2 and GCSEs
- 5) Attendance of children in need at school
- 6) Rate of exclusion of children in need from school
- 7) Social worker vacancy, turnover, absence, agency use

Plus number of NQSW that were offered and accepted posts

- 8) Distribution of working days from referral to assessment completion
- 9) Distribution of working days from CP strategy meeting to initial CP conference
- 10) Length of time in need
- 11) Percentage of CP reviews completed on time
- 12) Percentage of those on plan for 12/24 months re-referred to children's social care
- 13) Percentage of CPPs lasting 2 years or more
- 14) Percentage of children becoming subject of a CPP for second time within 2 years
- 15) Number of CPPs per 10,000 population
- 16) Percentage of CIN cases that close where the CPP case closes or the child becomes CLA (amended)

- 17) Children with a previous CPP subject to a further s47 enquiry
- 18) Children who are looked after and have a CPP
- 19) Rate of conversion of s47 to ICPC
- 20) Number of children subject of an application to court in last 6m (per 10,000)
- 21) Percentage of referrals leading to the provision of social care service
- 22) Rate of assessment per 10,000 population
- 23) Rate of s47 enquiries per 10,000 population
- 24) Percentage of referrals from police/health/schools/LA/other
- 25) Rate per 10,000of referrals where parental MH/Substance Misuse/DA is a factor
- 26) Children becoming subject of CPP physical/emotional/sexual/neglect per 10,000
- 27) Rate of ICPC per 10,000
- 28) Percentage of cases where social worker has seen child in accordance with CPP

Locally collected (and determined)

- 29) How do you know that vulnerable young people are receiving a suitable education?
- 30) How do you know how safe the children engaged with social care feel at home/school/community. What is done and how do you know if you have made a difference?
- 31) How do you know how helpful children think the relationship with their social worker is?
- 32) How do you know what children think about changes of social worker?
- 33) How do you know whether children (open cases) feel their wishes and feelings are listened to and that they understand what is happening and why?
- 34) How do you know what children feel about the difference professionals have made and how is this fed in to service development?

- 35) How do you know whether parents views have been considered by professionals?
- 36) How is this fed into service development?
- 37) How do you know what social workers think about whether their interventions have improved the safety of children/have received adequate support/manageable workloads/are able to spend enough time with children and what are you doing as a result?
- 38) How do you know that police/health/schools/early years/adult services/youth services/criminal justice agencies etc know how to identify concerns about a child?
- 39) How do you know that the above agencies understand thresholds?
- 40) How do you know that the above agencies know how to access early help?
- 41) How do you support children who do not meet the threshold for statutory intervention?
- 42) How do you know that the time from ICPC to the first core group is reasonable?
- 43) How do you understand and measure the timeliness and quality of professional decision making including quality of assessments/timeliness of decisions/whether plans have made a difference